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Supreme Court, U.S.
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No. 08-515

IN THE

SUPREME COURT OF THE UNITED STATES

NORTH TEXAS SPECIALTY PHYSICIANS,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether conduct that allegedly encourages physician price-fixing collusion, but undisputedly does not result in that collusion, violates Section 1 of the Sherman Act.

2. Whether conduct that allegedly encourages physician price-fixing collusion, but undisputedly does not result in that collusion, can be an "obvious anticompetitive effect on customers and markets" so as to be the basis for an antitrust violation under a "quick-look" analysis as set forth in *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999).

2. Whether a court must define a relevant market to find an antitrust violation under a "quick-look" analysis as set forth in *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999).

LIST OF PARTIES TO THE PROCEEDINGS

Petitioner North Texas Specialty Physicians was the respondent in the administrative proceedings and the petitioner in the court of appeals proceeding.

Respondent Federal Trade Commission was the respondent in the court of appeals proceeding.

CORPORATE DISCLOSURE STATEMENTS

Pursuant to Rule 29.6 of the Rules of this Court, petitioner North Texas Specialty Physicians states the following:

North Texas Specialty Physicians is a Texas non-profit corporation. It has no parent company and no stock owned by a publicly-traded company.

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North Texas Specialty Physicians ("NTSP") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The court of appeals' opinion is reported at 528 F. 3d 346. App. 3-52. The Federal Trade Commission's opinion (as modified) is available on its website at http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf. App. 53-130. The Federal Trade Commission's final order is available at http://www.ftc.gov/os/adjpro/d9312/051201finalorder.pdf. The Initial Decision of the Administrative Law Judge is available on the Commission's website at http://www.ftc.gov/os/adjpro/d9312/041116initialdecision.pdf. App. 131-297.

JURISDICTION

The court of appeals entered its judgment on May 14, 2008. A timely petition for rehearing was denied on July 18, 2008. App. 1-2. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. . . .

Section 5 of the Federal Trade Commission Act (the "FTC Act"), 15 U.S.C. § 45(a), provides in pertinent part:

> (1) Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful.
>
> (2) The Commission is hereby empowered and directed to prevent persons, partnerships, or corporations . . . from using unfair methods of competition . . . and unfair or deceptive acts or practices in or affecting commerce.

PRELIMINARY STATEMENT

The Federal Trade Commission and now the court of appeals have decided an important question of federal law that has not been, but should be, settled by this Court—whether conduct that allegedly "encourages" collusion or constitutes an "attempt" to collude can violate Section 1 of the Sherman Act or be used to show a violation of Section 1 of the Sherman Act under a quick-look analysis. The Commission and the court of appeals have held that it can.

The Commission and the court of appeals expressly rejected both a *per se* and rule of reason basis for their decisions and explicitly declined to make the factual findings required for either basis. Instead, the Commission and the court of appeals base their decisions solely on a "quick look" theory—described by the Commission as an "inherently suspect" analysis. In examining the actions of

NTSP, the Commission and the court of appeals looked to NTSP's conduct as a whole. The primary conduct considered was that NTSP conducted a poll as to what rates its participating physicians would accept and then published the average of those responses. The Commission and the court of appeals found that the poll and disclosure of the average "encouraged" individual physicians not to accept lower rates. They based their decisions that NTSP had violated Section 1 of the Sherman Act on this encouragement of physician collusion, although the Commission conceded that there is no allegation or proof of any physician having colluded (among themselves or with NTSP) or of any higher prices as a result of NTSP's actions. The Commission also conceded no relevant market or market power had been shown.

The "inherently suspect" or "quick look" analysis in this case is an improper interpretation of this Court's decision in *California Dental*, 526 U.S. 756 (1999). In *California Dental*, the Court reversed a Commission quick-look decision because such a truncated analysis is permitted only when "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets." *California Dental*, 526 U.S. at 770. The Commission and the court of appeals equate encouragement or possibility of physician collusion with "obvious anticompetitive effects" on "customers and markets." To allow a quick-look analysis in this case is to expand improperly this Court's decision in *California Dental*, allowing the Commission to condemn any

conduct that it deems to be "inherently suspect" as encouragement of collusion.

Further, the court of appeals' decision has created a clear circuit conflict on whether a relevant market must be defined to find a quick-look rule of reason analysis. The court of appeals affirmed the Commission's decision that it is not necessary to define a relevant market for a quick-look analysis under *California Dental*. This decision conflicts with the holding of the Court of Appeals for the Sixth Circuit, which requires that a relevant market be defined or "sufficiently well-known." Because there are conflicting holdings in the circuits interpreting this Court's holding in *California Dental*, this Court should determine which court of appeals has properly interpreted the requirements of market definition for application of the quick-look standard. This Court should adopt the standard of the Court of Appeals for the Sixth Circuit, which properly places the burden on the antitrust plaintiff to prove a rule-of-reason case.

The decisions of the Commission and the court of appeals greatly expand the scope of the Sherman Act, a criminal statute. If this interpretation is allowed to stand, boards of directors of professional and other associations will now face liability under a criminal statute for conduct deemed merely to encourage collusion. This results in the creation of a new antitrust violation outside the language of the Sherman Act, which itself lacks any prohibition of attempts to collude. In the health care industry, where cooperation among competing physicians is essential to achieving many cost efficiencies and quality improvements, allowing the decisions of the

Commission and the court of appeals to stand will have a chilling effect on physician behavior and health care innovation.

STATEMENT OF THE CASE

1. The Business Model of North Texas Specialty Physicians.

NTSP is a non-profit entity created to enter into "risk" contracts to provide medical care to thousands of patients for a set amount per month. *See* App. 5. Under a risk contract, an entity like NTSP enters into a contract with a "payor," such as an insurance company, to provide care for the patients covered under the payor's health plan. *Id.* NTSP is paid a set "capitation" payment or a bonus dependent on performance, and takes the risk that patients may require more medical care than predicted when the contract is signed. *Id.* NTSP subcontracts with physicians who actually treat the patients. App. 5-6. NTSP has succeeded in managing care under its risk contracts and has increased quality of patient care while saving costs. *See* App. 43.

NTSP also began to enter into some "non-risk" contracts. In a non-risk contract, NTSP performs only credentialing or other administrative services, and physicians contract with the payor to provide the medical care, on a fee-for-service basis. App. 6. One service NTSP can provide to a payor is reviewing and sending ("messengering") the payor's offer to the individual physicians on NTSP's panel. App. 133.

NTSP was one of at least 18 other physician associations which messengered payor offers to

physicians in the local area. NTSP cannot and does not bind any physicians on non-risk contracts — the physicians are free to accept or reject NTSP's messengered contracts or to contract with payors through avenues besides NTSP. App. 157-58. NTSP physicians made independent decisions on both poll responses and payor offers that were messengered. App. 157-58, 163, 201-02, 204-05. The rates received by physicians through NTSP were the same or lower than those rates offered by payors directly to the physicians or through other entities. App. 41, 120, 168, 181, 184, 190-91, 206, 216, 271-73.

With regard to non-risk activities, NTSP seeks to improve the medical care provided to patients through a "spillover" business model. Under that model, quality and efficiency improvements physicians learn from managing medical care under NTSP's risk contracts will "spill over" to non-risk treatment if NTSP can keep the same team of key physicians working together. *See* App. 7, 43, 105. As the court of appeals explained, "There is some evidence in the record of spillover effects from the risk contract to the non-risk panels, and there is evidence that NTSP physicians perform as well or better than non-NTSP groups." App. 43.

To keep its team of trained and coordinated physicians together and to promote spillover benefits, NTSP becomes a party to and messengers only those non-risk contracts likely to interest a majority of NTSP's risk physicians. App. 6-7. NTSP conducts a physician poll to determine the reimbursement rate likely to interest physicians to participate in non-risk contracts. *Id.* NTSP's participating physicians, including those on NTSP's

Board, are given only the single mean, median, and mode aggregated across the responses of all specialties, which is what NTSP uses when it decides whether to participate in risk and non-risk contracts. *Id.* Whether or not NTSP chooses to messenger a payor's non-risk contract, each physician chooses independently whether or not to accept that contract or to contract with the payor directly or through another physician association.

2. The Decisions of the Administrative Law Judge and the Federal Trade Commission.

The Commission's complaint attacked the legality of NTSP's spillover business model, alleging that NTSP's refusal to messenger payor contracts below a specific rate was collective price-fixing in violation of the FTC Act. App. 60.

After a two-week hearing during which the Commission presented no empirical evidence, an ALJ ruled against NTSP. App. 134. The Commission affirmed. App. 55-56. The Commission recognized that a *per se* analysis was inappropriate in this case and instead relied exclusively on the "quick look" analysis set forth by this Court in *California Dental*. App. 56-57. It is undisputed that a rule of reason analysis could not be conducted because Complaint Counsel did not attempt to define a relevant market, the Commission did not find a relevant market, and the Commission also made no findings regarding market power. App. 119-20, 241-42.

The Commission based its decision on NTSP's conduct "as a whole," relying primarily on NTSP's use of the poll. App. 84-90. The other conduct

referenced by the Commission involved chiefly NTSP's exercise of contractual termination rights in two instances, one involving a breach of contract by a payor and the other an attempt by a payor to displace NTSP's risk contract with a major employer. App. 94-97, 171-75, 191-98. The Commission did not address NTSP's reasons for exercising its contract rights and did not make any determination as to how many physicians were affected.

The undisputed evidence showed no physician price-fixing collusion. The ALJ concluded and the Commission agreed[1] that:

- NTSP cannot and does not bind physicians to non-risk contracts (App. 91, 158, 247);
- physicians did not consult with each other about their responses to the poll and do not know how others responded to the poll (App. 61, 163, 247);
- physicians did not consult with each other when making decisions on non-risk payor contracts (App. 158, 247);
- there was no evidence that one or more physicians agreed with each other to reject a non-risk payor offer (App. 158, 247);
- there was no evidence that any physician agreed with any other entity (including NTSP) to reject a non-risk payor offer (App. 158, 247); and
- there was no evidence that any physician rejected a non-risk payor offer based on a

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[1] *See* App. 56 (The Commission states, "We adopt the findings of fact of the Initial Decision to the extent those findings are not inconsistent with this opinion.").

power of attorney or the physician participation agreement with NTSP (App. 158, 247).

The ALJ and the Commission also found that the rates offered by payors through NTSP were the same *or less* than those offered by the payors directly to physicians and through other physician groups. App. 120, 168, 181, 184, 190-91, 206, 216, 271-73.

The Commission acknowledged at least some validity to the procompetitive justifications offered by NTSP—most notably, that spillover efficiencies were possible. App. 114.

3. The Court of Appeals Decision.

The court of appeals affirmed the decision of the Commission. App. 4. In doing so, the court of appeals also recognized that a *per se* analysis was inappropriate and instead relied exclusively on a "quick look" analysis. App. 8, 24, 28. The court of appeals also failed to address the issues of relevant market or market power, and, therefore, a rule of reason was not applied.

The court of appeals' analysis also considered NTSP's conduct "as a whole," but focused primarily on the fact that NTSP conducted a poll as to what rates its participating physicians would accept and then published the average of those responses. App. 6-7, 13, 29-31, 34-35, 41-42. The court of appeals ruled that the poll and disclosure of the poll results "encouraged" individual physicians not to take lower rates and based its decision that NTSP had violated Section 1 of the Sherman Act on that encouragement. App. 31-32, 34-35, 45. The court of

appeals decision is replete with references to the alleged attempted or encouraged collusion between NTSP physicians and relies extensively on hypothetical effects of the same conduct. App. 27-28, 31-32, 34-36, 45. The court of appeals found that there were no actual effects on market prices—physicians did not receive higher rates through NTSP than what physicians and other physician groups were already receiving. App. 41.

The court of appeals acknowledged at least some validity to the procompetitive justifications offered by NTSP. The court of appeals stated there was "some evidence in the record of spillover effects from the effects from the risk contract to non-risk panels [of NTSP]" and also stated that the spillover justification had "facial plausibility." App. 41, 43. The court of appeals also characterized as "permissible goal[s]" NTSP's limiting its resources to messengering contracts of interest to at least a majority of NTSP's physicians, as well as avoiding medically or legally risky contracts. App. 45 ("The second justification NTSP offers is that it 'need[ed] to avoid expending scarce resources in analyzing, messengering, and participating in contracts of interest to relatively few of the physicians.' We do not disagree that this is a permissible goal. ...The third justification was 'the avoidance of legally or medically risky situations' and that NTSP was 'surely justified in refusing to sign payor contracts that present these problems.' These are certainly permissible goals.").

The American Medical Association and the Texas Medical Association appeared as *amici curiae* in support of NTSP in the court of appeals.

challenging the Commission's improper use of a quick-look analysis. App. 3.

REASONS FOR GRANTING THE PETITION

I. The Commission and the court of appeals relied only upon a "quick look" analysis and admittedly have no support for applying a "*per se*" or "rule of reason" analysis.

A contract or conspiracy, if proven, can be an unlawful restraint of trade under one of three separate theories: (1) the rule of reason, (2) the condemnation of a narrow range of actions as *per se* harmful to competition, or (3) a truncated or "quick-look" analysis. *California Dental*, 526 U.S. 756, 763 (1999). The rule of reason standards apply to most contracts or conspiracies and are "presumptively applied" by this Court. *Texaco Inc. v. Dagher*, 547 U.S. 1, 5 (2006); *see also Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49 (1977) (the rule of reason is the prevailing standard of analysis). In this case, the Commission and the court of appeals recognized that a *per se* analysis was inappropriate and also that there was no proof of required elements for a rule of reason analysis. Therefore, in concluding NTSP committed an antitrust violation, the Commission and the court of appeals relied exclusively on the "quick look" analysis set forth by this Court in *California Dental*.

A. Both the Commission and the court of appeals admit that this case is not appropriate for *per se* treatment.

The *per se* analysis is limited by this Court to restraints that have "manifestly anticompetitive effects" and "lack... any redeeming virtue." *Leegin Creative Leather Products, Inc. v. PSKS, Inc.*, 127 S. Ct. 2705, 2713 (2007) (quoting *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 50 (1977) and *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 289 (1985)). This Court also stated that application of the *per se* analysis is "appropriate only after courts have had considerable experience with the type of restraint at issue, and only if courts can predict with confidence that it would be invalidated in all or almost all instances under the rule of reason." *Id.* (quoting *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 9 (1979) and *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 344 (1982)). Both the Commission and the court of appeals recognized that a *per se* analysis should not be applied to NTSP's conduct. App. 28, 56-57.

Forgoing the *per se* rule was not a gratuitous concession by the Commission. Its own economic expert admitted, and the ALJ found, that NTSP's conduct was different from that in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982): (1) NTSP had no power to bind physicians on contracting decisions (App. 15-16, 157-58);[2] (2) there

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[2] In *Maricopa*, the "participating doctors agree[d] to accept [the maximum fee schedule] as payment in full for services performed for patients insured under plans approved by the foundation." 457 U.S. at 339.

was no evidence of agreements to reject contract offers either among physicians or between physicians and NTSP (App. 15-16, 157-58);[3] and (3) there was no evidence of physicians rejecting contract offers based on NTSP's Physician Participating Agreement or powers of attorney (App. 15-16, 157-58).[4] Further, the physicians did not even consult among themselves on the responses to the polls or non-risk payor offers. App. 15-16, 61, 158, 163, 247. These significant departures from the facts of *Maricopa* remove NTSP's conduct from consideration as a *per se* price-fixing agreement. The Commission conceded that point when it gave up viewing this case as a *per se* price-fixing case. The court of appeals similarly does not rely on a *per se* analysis or a comparison to the facts of *Maricopa*.

The Commission's concession is consistent with this Court's jurisprudence. In examining the actions of NTSP, the primary conduct considered by the Commission and the court of appeals was that NTSP conducted a poll as to what rates its participating physicians would accept and then published the average of those responses. *See, e.g.*, App. 6-7, 13, 29-31, 34-35, 41-42, 84-90. The Commission and the court of appeals found that the poll and disclosure of the poll results "encouraged" individual physicians not to take lower rates and based their decisions that NTSP had violated Section 1 of the Sherman Act on this fact. Conduct of this type has been held by this

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[3] In *Maricopa*, there were "agreements among competing physicians setting, by majority vote, the maximum fees." 457 U.S. at 335.

[4] In *Maricopa*, the membership agreements "contain the promise to abide by maximum fee schedules." 457 U.S. at 336.

Court in *United States v. United States Gypsum Co.* not to constitute a *per se* violation. 438 U.S. 422, 441 n.16 (1978) (exchanging price information with competitors is not a *per se* violation because it can increase economic efficiency and render markets more competitive, in certain circumstances). The Commission also has commented on similar activities and found them to have possible procompetitive benefits and to not necessarily raise antitrust concerns. *See* Bay Area Preferred Physicians Advisory Opinion, Federal Trade Commission (September 23, 2003), *available at* http://www.ftc.gov/bc/adops/bapp030923.shtm (taking a neutral stance on an IPA's request not to service "contracts in which only a minority of [the IPA's] members participate") and PriMed Physicians Advisory Opinion, Federal Trade Commission (February 6, 2003), *available at* http://www.ftc.gov/bc/adops/030206dayton.shtm (explaining the procompetitive effects of information sharing in the health care industry, even among competing physicians); Federal Trade Commission and Department of Justice, Statements of Antitrust Enforcement Policy in Health Care, Statement 5, *available at* http://www.ftc.gov/bc/heathcare/industryguidc/policy/hlth3s.pdf ("The collective provision by competing health care providers to purchasers of health care services of factual information concerning the fees charged currently or in the past for the providers' services, and other factual information concerning the amounts, levels, or methods of fees or reimbursement, does not necessarily raise antitrust concerns.... Such factual information can help purchasers efficiently develop reimbursement terms to be offered to providers and may be useful to a purchaser when provided in

response to a request form the purchaser or at the initiative of providers.").

Therefore, it would be improper, as recognized by the Commission and the court of appeals, to consider NTSP's conduct in this case using a *per se* analysis. That the case against NTSP is not a proper *per se* case also militates against the use of a quick-look analysis, as discussed *infra*.

B. It is undisputed that the Commission and the court of appeals failed to find the necessary elements for a rule of reason analysis.

As this Court explained in *California Dental*, application of a rule of reason analysis is required if the conduct at issue "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition." 526 U.S. at 771. The rule of reason requires definition of a relevant market, a showing of sufficient market power to adversely affect competition in that market, and a showing of a net anticompetitive effect in that market. *Leegin*, 127 S. Ct. at 2712-13. If even one requirement is not met, there is no rule of reason violation, as in this case. *See, e.g., Care Heating & Cooling, Inc. v. American Standard, Inc.*, 427 F.3d 1008, 1014 (6th Cir. 2005) (listing requirements of proof for rule of reason and finding plaintiff failed to establish element of adverse effects on the market).

It is undisputed that Complaint Counsel did not attempt to define the relevant market, and the Commission did not find a relevant market. App. 119-20, 241-42. Without a relevant market, there is

no proof of market power. *See Worldwide Basketball & Sport Tours, Inc. v. NCAA*, 388 F.3d 955, 961 (6th Cir. 2004) (the relevant market must be readily apparent or adequately defined to assess market conditions and effects). It is undisputed that the Commission made no findings regarding market power. App. 119-20. The court of appeals also failed to address the issues of relevant market or market power. App. 46.

The Commission also failed to show, and the court of appeals did not find, the third element—anticompetitive effect on the market. Under a rule of reason analysis, any restraint of trade must be evaluated by weighing its anticompetitive effects against any procompetitive benefits. *California Dental*, 526 U.S. at 771. It is undisputed that NTSP did not change physician behavior or increase the physicians' prices. Indeed, the ALJ, the Commission, and the court of appeals all found that physicians did not receive higher rates through NTSP than what other physicians and physician groups were already receiving. *See* App. 41, 120, 168, 181, 184, 190-91, 206, 216, 271-73. The ALJ also found that none of NTSP's challenged conduct changed physician behavior, as admitted by Complaint Counsel's own expert. App. 15-16, 157-58. Therefore, the Commission and court of appeals failed to show anticompetitive effect.

Under a rule of reason analysis, no antitrust violation could be found against NTSP because the Commission and court of appeals failed to find the required elements of relevant market, market power, and net anticompetitive effect. The failure of the Commission and court of appeals to articulate a

relevant market is also fatal to the use of a quick-look analysis, as discussed *infra*.

C. The Commission and court of appeals rely exclusively on the "quick look" analysis to find an antitrust violation by NTSP.

The Commission and the court of appeals decisions rely exclusively on a "quick look" analysis—as they must because, as explained above, the avenues of *per se* or rule of reason were not available. As a result, this case stands or falls on whether the decision to use a quick-look analysis was correct.

This Court set forth in *California Dental* the high standard for use of the "quick look" analysis. There the Court stated that to apply anything less than the full-blown rule of reason analysis requires that the "great likelihood of anticompetitive effects" of the defendant's conduct must be "easily ascertained." 526 U.S. at 771. The Court also has stated that the reason why a case is not an appropriate *per se* case may also determine why a quick-look analysis is not appropriate. *Texaco Inc. v. Dagher,* 547 U.S. 1, 7 n.3 (2006) ("But for the same reasons that *per se* liability is unwarranted here, we conclude that petitioners cannot be held liable under the quick look doctrine.").

As explained below, the findings of the Commission and the court of appeals fall well short of the high threshold *California Dental* set for dispensing with proof of the full rule of reason elements, improperly rely on evidence of mere encouragement of or attempt to collude, and fail to

articulate any relevant market by which to judge anticompetitive effect on customers and markets. The court of appeals decision has misinterpreted critical requirements of this Court's "quick look" analysis – a federal question with grave implications for professional and trade associations and health care throughout the country.

II. This Court should rule that there is no Sherman Act violation for attempts to collude.

A. The language of Section 1 of the Sherman Act does not support liability for attempts to collude.

Attempting to conspire or encouraging others to conspire is not a violation of Section 1 of the Sherman Act. Section 1 states:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

15 U.S.C. § 1. By its plain language, the Act declares illegal an *actual* contract, combination, or conspiracy, not a mere attempt to engage in a conspiracy or conduct that encourages, but does not result in, a conspiracy. As this Court has stated, "there can be no liability under Section 1 in the absence of agreement." *Fisher v. City of Berkeley*, 475 U.S. 260, 266 (1986); *see also Bell Atlantic Co. v. Twombly*, 127 S. Ct. 1955, 1964 (2007) (holding that stating a section 1 claim "requires a complaint with

enough factual matter (taken as true) to suggest that an agreement was made").

Numerous other decisions of the court of appeals and other courts reiterate the requirement of actually engaging in a conspiracy for any Section 1 violation. *See, e.g., Tunica Web Advertising v. Tunica Casino Operators Ass'n*, 496 F.3d 403, 409 (5th Cir. 2007) (holding that, to state a Section 1 claim, plaintiff must show that defendants engaged in a conspiracy); *Johnson v. Hospital Corp. of Am.*, 95 F.3d 383, 392 (5th Cir. 1996) (finding evidence of "mere opportunity to conspire" insufficient); *Olde Monmouth Stock Transfer Co. v. Depository Trust & Clearing Corp.*, 485 F. Supp. 2d 387, 396 (S.D.N.Y. 2007) (dismissing antitrust claims for attempting to conspire, citing *Fisher*).

NTSP repeatedly cited to the Commission and court of appeals the case of *United States v. American Airlines, Inc.*, 743 F.2d 1114 (5th Cir. 1984), in which the court of appeals explicitly disallowed a cause of action for attempting or encouraging a conspiracy under Section 1 of the Sherman Act. *Id.* at 1119. The court of appeals without explanation did not address its prior decision.

Therefore, an attempt to conspire or encouragement of others to conspire cannot be a basis for a violation of Section 1 of the Sherman Act.

B. The holdings of the Commission and the court of appeals equate to a ruling that NTSP violated Section 1 of the Sherman Act by encouraging or attempting collusion.

The Commission and the court of appeals improperly relied on evidence of "attempt" to conspire as evidence of a violation of Section 1 of the Sherman Act, thereby expanding the scope of Section 1 of the Sherman Act to include "attempts" to violate. This "attempt" was part of the basis for the Commission's and the court of appeals' ruling that NTSP was in violation of Section 1 of the Sherman Act.

The court of appeals' decision is replete with references to the alleged attempted or encouraged collusion between NTSP physicians which never occurred and relies extensively on hypothetical effects of the same conduct:

- The court of appeals' decision notes that "the FTC did not rely on empirical evidence," but instead on a "*theoretical* basis." App. 27-28 (emphasis added);

- "The FTC concluded, however, that the fact that poll results were disclosed to all NTSP physicians, regardless of whether they responded to the poll, *encouraged* physicians 'to reject price offers below the minimum fees indicated.'" App. 34 (emphasis added);

- "[I]t is obvious that the practice of reporting poll results *encouraged* other physicians to reject offers that equaled the

fee they reported in the poll as the minimum." App. 34 (emphasis added);

- "Armed with knowledge from NTSP's polling, those physicians would also be *encouraged* to hold out for a fee equal to or even less than NTSP's minimum fee." App. 34 (emphasis added);

- "[S]pecific activities that we conclude are anticompetitive, which include (1) the *communication* of the mean, median, and mode results from the polling regarding fees,...(3) *urging* physicians to reject fee offers from payors...." App. 45 (emphasis added); and

- "The FTC further found that 'NTSP actively *encouraged* [physicians] to reject the offers' below the minimum fees indicated in the polls. That finding is supported by the record and is evidence of concerted action to fix prices." App. 35 (emphasis added).

Given the undisputed evidence of no price-fixing collusion between or among the physicians and no higher prices, the court of appeals decision can be based only on decisions made in NTSP board of directors meetings which the court of appeals relied on as satisfying the collusion requirement of Section 1. However, when determining if boardroom decisions had a market-wide anticompetitive effect (a requirement of the rule of reason), the court of appeals relied extensively on NTSP's purported

"encouragement" of price-fixing collusion by physicians, which never occurred.

Because neither the Commission nor the court of appeals could find evidence of agreements relating to prices, effects on physician behavior, or effects on physician prices, this reliance on "encouragement" of a Section 1 violation equates to a finding that NTSP has antitrust liability for encouraging physician price-fixing. As explained above, both the plain language of Section 1 of the Sherman Act, as well as this Court's own holdings, require an *actual* agreement to support a Section 1 violation. The court of appeals' decision equates to a finding that there is Section 1 liability for "attempting" to facilitate such an agreement. This Court should clarify the plain language of Section 1 and follow the court of appeals' prior decision in *American Airlines* in holding explicitly that an "attempt" to conspire is not a violation of Section 1 of the Sherman Act.

III. The misinterpretation of the quick-look analysis and its use in this case conflicts with the prior holdings of this Court.

A. *California Dental* held that a quick-look analysis is appropriate only when there are obvious anticompetitive effects on customers and markets, and no plausible justification.

As explained above in Section 1, the Commission and the court of appeals relied exclusively on the "quick look" analysis of *California Dental* to find an antitrust violation by NTSP in this case. Whether a "quick look" analysis is appropriate is a question of law that this Court reviews *de novo*. *Craftsman*

Limousine, Inc. v. Ford Motor Co., 363 F.3d 761, 772 (8th Cir. 2004); *Nat'l Bancard Corp. v. VISA U.S.A., Inc.*, 779 F.2d 592, 596 (11th Cir. 1986).

When a *per se* analysis is not appropriate, *California Dental* dictates that some form of the rule of reason must apply. The Commission and the court of appeals relied solely on a "quick look" analysis, rather than the full-blown rule of reason analysis (the requirements of which were undisputedly not met by the Commission in this case). This Court permits a quick-look analysis only when the "great likelihood of anticompetitive effects" of the defendant's conduct is "easily ascertained," 526 U.S. at 771, and "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets." *Id.* at 770.

Where the circumstances of the restriction are complex, "assumption alone will not do." *Id.* at 775 n.12. In *California Dental*, the Court was concerned that the Commission and the lower court had not "properly identified the theoretical basis for the anticompetitive effects and considered whether the effects are actually anticompetitive" before shifting the antitrust burden to the defendant. *Id.* In *California Dental*, the Court concluded that the Commission and the court below had not properly connected at least one alleged violation (which limited advertising services) with the alleged anticompetitive effect on output (limiting delivery of dental services). *Id.* at 776. This was one example of the inappropriately-abbreviated analysis condemned by the Court in *California Dental*.

Further, under *California Dental,* even if the initial threshold of "great likelihood of anticompetitive effects" of the defendant's conduct being "easily ascertained" had been met, a court cannot properly abbreviate its rule of reason analysis if a plausible claim of justification has been articulated:

> As a matter of economics [the respondent's] view may or may not be correct, but it is not implausible, and neither a court nor the Commission may initially dismiss it as presumptively wrong.
>
> . . .
>
> The point, rather, is that the plausibility of competing claims about the effects of the professional advertising restrictions rules out the indulgently abbreviated review to which the Commission's order was treated.

Id. at 775, 778.

Therefore, if there is either (1) no conduct that could result in obvious anticompetitive effect on customers and markets under a proper interpretation of this Court's precedent or (2) a plausible justification that was presumptively dismissed, it was improper for the Commission and the court of appeals to employ a "quick look" analysis under *California Dental.*

B. The Commission and the court of appeals improperly relied on hypothetical effects of encouraging or attempting collusion by physicians as evidence of "obvious" anticompetitive effects on customers and

markets, in violation of the holding of *California Dental*.

In ruling that a "quick look" analysis is appropriate, the Commission and the court of appeals rely primarily on the hypothetical effect of the NTSP's board's actions in encouraging physician collusion, characterizing such perceived attempts to conspire as being "obvious" and "easily ascertained." App. 27-29, 34, 37, 104.

The focus of the Commission and the court of appeals on these hypothetical effects confounds the distinction between "restraint" and the "obvious anticompetitive effect on customers and markets" of the restraint. The actual collusion found by the Commission was the decisions made by the eight physicians on NTSP's board of directors. App. 4, 13-15. Rather than measuring the effect that board-level restraint had, the Commission and court of appeals hypothesize a broader, unproven "encouraged" restraint—possible collusion by physicians in dealing with payors.

The Commission and court of appeals ignore the definition of anticompetitive effect on customers and markets and misinterpret the purpose of the "quick look" analysis. An anticompetitive effect occurs when the conduct at issue decreases output or increases prices. *Anago, Inc. v. Tecnol Medical Products, Inc.*, 976 F.2d 248, 249 (5th Cir. 1992); *Les Shockley Racing, Inc. v. Nat'l Hot Rod Ass'n*, 884 F.2d 504, 508 (9th Cir. 1989). The purpose of the "quick look" analysis is to predict the economic results of an already-existing restraint—not to predict whether collusion will occur. *California*

Dental, 526 U.S. at 781 (quick-look analysis is appropriate when the experience of the market allows "a confident conclusion about the principal tendency of a restriction"). Anticompetitive effect on customers and markets is an economic concept, not a collusion concept. The physicians supposedly affected by NTSP's encouragement are not "customers and markets." Customers and markets, when properly defined, would be putative victims of the actual board-level collusion challenged by the Commission; they would not be possible co-conspirators of a broader unproven conspiracy.

By focusing on the possibility of collusion from the alleged encouragement, the Commission and the court of appeals improperly extended the "quick look" test to allow consideration of anticompetitive effects from a restraint not shown to have occurred, only to have been "encouraged." If collusion by physicians had been proven, the Commission would have pursued the case under a *per se* theory.

The court of appeals inferred that the physicians anticipated that their responses would raise or lower the average fee that NTSP would use to negotiate the payor contracts. App. 30. In addition, the court of appeals inferred that NTSP's refusal to forward payor offers lower than the minimum fees "encouraged" physicians otherwise willing to accept lower fees to hold out for a fee greater than or equal to NTSP's minimum fee. App. 34-35. The court of appeals then concluded that the possibility of physician collusion constituted anticompetitive effects sufficient to justify an abbreviated quick-look analysis rather than conducting a full rule-of-reason inquiry. App. 31-32, 34-35, 45.

But possible future collusion is only a possibility, not an actual effect. Nor is there any actual anticompetitive effect on customers and markets unless one assumes that the possible became reality. NTSP does not charge payors for treating patients under a non-risk contract; physicians do that in bills sent directly to the payor. To reach the effects considered by the Commission and the court of appeals, they had to take the extra step of hypothesizing a widescale physician collusion—a collusion which never occurred.

In effect, the court found anticompetitive effects based on what would have occurred if NTSP had successfully encouraged third-parties to collude. The *California Dental* decision itself, as well as subsequent interpretations of the quick-look analysis, use an abbreviated analysis only to predict the effect of an actual restraint on customers, not to predict whether competitors *might* end up colluding and then allowing consideration of the effects of that hypothetical collusion. 526 U.S. at 781; *see Worldwide Basketball & Sport Tours, Inc.*, 388 F.3d at 961 (holding quick-look analysis may only be used when the relevant market is sufficiently known and defined to determine whether the *challenged practice* impairs competition); *Continental Airlines, Inc. v. United Airlines, Inc.*, 277 F.3d 499, 515-16 (4th Cir. 2002) (rejecting a quick-look analysis where the plaintiff had failed to show that any restraint of trade had occurred); *Dickson v. Microsoft Corp.*, 309 F.3d 193, 202, 205-06 (4th Cir. 2002) (recognizing distinct elements of conspiracy and unreasonable restraints of trade imposed by that conspiracy).

Therefore, the Commission and the court of appeals misinterpreted *California Dental* and erred in using the quick-look analysis in this case. Because the quick-look analysis should not have been used, the decision must be reversed.

IV. If any portion of the conduct relied upon by the Commission and the court of appeals for a violation of Section 1 of the Sherman Act or anticompetitive effects was encouraged or attempted collusion, reversal is required.

The Commission and the court of appeals both considered NTSP's conduct "as a whole," which included the improper evidence of attempt to conspire and hypothetical conduct of unproven conspirators explained above. *See* App. 29 ("The FTC's ultimate conclusion was that the 'activities of [NTSP], *taken as a whole*, amount to horizontal price fixing which is unrelated to any procompetitive efficiencies.'") and App. 46 ("The Commission's determination that NTSP's conduct, *taken as a whole*, amounted to horizontal price-fixing that is unrelated to procompetitive efficiencies is supported by the law and substantial evidence.") (emphasis added). When an agency decision (and, by extension, a court of appeals' affirmation of that decision) is based on an improper legal standard, reversal is appropriate. *SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943) ("[A]n order may not stand if the agency has misconceived the law."); *Moore v. Sullivan*, 895 F.2d 1065, 1066 (5th Cir. 1990) (when agency applies erroneous legal standard in assessing evidence, agency must reconsider the case). Also, when an agency decision (and, by extension, a court of

appeals' affirmation of that decision) is reached on a totality of the evidence that includes improper evidence or ignores evidence, the decision must be reversed. Under the Commission's Rules of Practice and the Administrative Procedure Act, the Commission's decision must be based "on consideration of the whole record relevant to the issues decided." 5 U.S.C. § 556(d); 16 C.F.R. §§ 3.51(c)(1), 3.54. When an ALJ relies on improper or incorrect evidence in making a decision, there is not substantial evidence to support that decision. *Randall v. Sullivan*, 956 F.2d 105, 109 (5th Cir. 1992) (remanding case when ALJ decision relied on incorrect medical report). *See also Florida Power & Light Co. v. Lorion*, 470 U.S. 729, 744 (1985) (holding remand is proper "[i]f the record before the agency does not support the agency action, if the agency has not considered all relevant factors, or if the reviewing court simply cannot evaluate the challenged agency action on the basis of the record before it..."); *BizCapital Business & Industrial Development Corp. v. Comptroller*, 467 F.3d 871, 873 (5th Cir. 2006) (remand is proper if an agency has not considered all the relevant facts in its decision or has improperly applied the law).

Therefore, because the decisions of the Commission and the court of appeals were based in large part on the erroneous determination that encouragement of or attempted collusion could violate Section 1 of the Sherman Act or constituted anticompetitive effects under a "quick look" analysis, their decisions must be reversed.

V. The decision of the court of appeals that a relevant market is not necessary to find a

quick-look violation creates a clear circuit conflict on this issue.

It is undisputed that the Commission's counsel did not attempt to define the relevant market, and the Commission did not find a relevant market. App. 119-20, 241-42. The Commission specifically held that "proof of market definition and market power is *not* required in this case because Respondent did not meet its burden of establishing a legitimate justification for NTSP's inherently suspect practices." App. 119.

The court of appeals also failed to address the issues of relevant market or market power, defining neither and not addressing NTSP's argument that proof of both was required. *See generally* App. 3-52. Instead—without ever considering or deciding the relevant product or geographic market—the court of appeals reached the broad conclusion that "'the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency' of NTSP's challenged practices follows from the 'look' the FTC conducted in this case, even though that 'look' was less than a full-blown market analysis." App. 46 (quoting *California Dental*, 526 U.S. 781).

The court of appeals' decision that a relevant market need not be defined in order to prove a violation under a quick-look rule of reason creates a circuit conflict because the Court of Appeals for the Sixth Circuit has held the opposite. In *Worldwide Basketball & Sport Tours, Inc. v. NCAA*, the Court of Appeals for the Sixth Circuit held that:

> abbreviated or "quick-look" analysis may only be done where the contours of the market and, where relevant, sub-market, are sufficiently well-known or defined to permit the court to ascertain without the aid of extensive market analysis whether the challenged practice impairs competition.

388 F.3d 955, 961 (6th Cir. 2004). In *Worldwide Basketball*, the court also explained that the burden was on the plaintiff in an antitrust case to show the relevant market and that the lower court's attempt to define a non-obvious market without a proper analysis was error. *Id.* at 962-63. The lower court had defined the market as Division I mens' college basketball. *Id.* at 962. Rejecting this definition, the Court of Appeals for the Sixth Circuit found that "the basis for that view is not developed in the record," and specifically pointed to the fact that the plaintiffs had "presented no evidence of 'products or services that are either (1) identical to or (2) available substitutes for the defendant's product or service'" and also that the plaintiffs' expert witness admitted he did no test to consider who was in competition with plaintiffs and instead derived his market analysis from only "common sense." *Id.* at 962.

Similar to *Worldwide Basketball*, here there is no basis in the record to define a relevant product or geographic market. As the ALJ stated in this case, "it could not be more clear" that the Commission's expert did not attempt to prove a relevant market. App. 242 (and quoting testimony of the Commission's expert: "Q. And by the way, you're

not positing any relevant market in this case, isn't that correct? A. That's correct.").[5]

Further, the relevant product and geographic markets are not "sufficiently well-known" in this case. In this case, there are numerous levels of competition involved—competition between physicians within a specialty; competition between certain partially-overlapping physician specialties; competition between insurance payors; competition between payors and physician groups that provide insurance services; and many more. There are also several levels of consumers—employers who choose to what insurance services they will subscribe; individuals who choose to what insurance services they will subscribe; individuals who choose their individual physicians; and physicians who refer patients to other physicians. There is also the complicated multi-county geographic market of the Dallas-Fort Worth, Texas Metroplex. Physicians in eight different counties have accepted at least one contract messengered by NTSP. App. 146. None of these intricacies was discussed by the Commission or the court of appeals.

The Commission and the court of appeals cannot rely on any anticompetitive effects to relieve the burden of defining a relevant market. In *FTC v. Indiana Federation of Dentists*, this Court held that:

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[5] While the ALJ did attempt to define a market, that market was not based on a proper analysis, and the Commission overturned those findings on their *de novo* review. App. 118-20.

> Since the purpose of the inquiries into market definition and market power is to determine whether an arrangement has the potential for genuine adverse effects on competition, "proof of actual detrimental effect, such as reduction of output," can obviate the need for an inquiry into market power, which is but a "surrogate for detrimental effects."

476 U.S. 447, 460 (1986). Here, however, it is undisputed that NTSP did not change physician behavior or increase the physicians' prices. Indeed, the ALJ, the Commission, and the court of appeals all found that physicians did not receive higher rates through NTSP than what physicians and other physician groups were already receiving. *See* App. 41, 47, 120, 168, 181, 184, 190-91, 206, 216, 271-73. The ALJ also found that none of NTSP's challenged conduct changed physician behavior, as admitted by the Commission's own expert. App. 15-16, 157-58. The Commission made no showing of any time period any specific physician ceased providing services to a payor's insureds, much less any reduction of output in the market.

The failure of the Commission and court of appeals to require proof of a relevant market, and the subsidiary elements of market power and market effect, undermine any possible argument that NTSP's board of director decisions had an obvious anticompetitive effect on customers and markets, as required by *California Dental* for a quick-look analysis. The Commission and court of appeals decisions recognize there was no physician price-fixing or higher prices charged by physicians. There

were some miscellaneous situations challenged as part of the Commission's review of NTSP's conduct as a whole—primarily a situation in which NTSP challenged Cigna for breaching a provision allowing open access to Cigna's contract for any NTSP physician and a situation in which NTSP terminated and withdrew from a contract which was being used by United competitively to displace NTSP's treatment of a major employer's employees under NTSP's *risk contract.* The Commission at no time made any showing of how many physicians, if any, ceased accepting patients from those two payors as a result of NTSP's conduct and consequently made no showing of any impact on a relevant market. The Commission at no time made any showing of what the volume of commerce was for any service provided by physicians having contracts messengered through NTSP. The Commission never made any showing of market share, or market power, for NTSP.

These failures to show a relevant market, market power, and market effect are used by the Commission to camouflage an "inherently suspect" case based on trivial situations without any antitrust significance. *California Dental* requires a showing of obvious anticompetitive effect on customers and markets. No market has been shown in this case. And no showing of adverse impact on customers has been shown, much less any impact the significance of which can be measured in the contours of a defined relevant market.

Because the Commission and the Fifth Circuit Court of Appeals utilized a quick-look analysis without defining a market, either by the proper analysis, or a finding that the market was

sufficiently well-known, the holding in this case conflicts with the holding of the Court of Appeals for the Sixth Circuit. Because both these cases interpret this Court's holding in *California Dental*, this Court should determine which court of appeals has properly interpreted the requirements of market definition for application of the quick-look standard. This Court should adopt the standard of the Court of Appeals for the Sixth Circuit, which properly places the burden on the antitrust plaintiff to prove a rule-of-reason case and forbids application of a quick-look analysis without conducting a determination of the relevant market or finding a well-known market.

VI. The Court should grant certiorari because this case presents an issue of importance to the health care industry and an issue that will continue to arise and affect health care innovation due to agency involvement.

The decisions of the Commission and the court of appeals are appropriate for a grant of certiorari for three reasons: (1) they have decided an important question of federal law concerning attempted violations of Section 1 of the Sherman Act that has not been, but should be, settled by this Court; (2) they have decided an important federal question in a way that conflicts with the *California Dental* decision of this Court by relying on the theoretical anticompetitive effects of "attempted" collusion and in allowing a "quick look" analysis of an important situation of health care innovation; and (3) they have created a clear conflict with another circuit on the proper interpretation of *California Dental*.

First, the decisions of the Commission and the court of appeals greatly expand the scope of the Sherman Act, a criminal statute, by recognizing a violation for "attempted" collusion. If this interpretation is allowed to stand, boards of directors of professional and other associations will now face liability under a criminal statute for conduct deemed merely to encourage collusion. This results in the creation of a new antitrust violation outside the language of the Sherman Act, which itself lacks any prohibition of attempts to collude. In the health care industry, where cooperation among competing physicians is essential to achieving many cost efficiencies and quality improvements, the decisions of the Commission and the court of appeals will have a chilling effect on physician behavior and health care innovation.

Second, because the decisions of the Commission and the court of appeals misinterpreted *California Dental* by using the "quick look" analysis in this case, the decisions must be reversed. Allowing the Commission's misinterpretation of *California Dental* will give the Commission free rein to declare fact situations to have "obvious" anticompetitive effects under a quick-look analysis based solely on a finding that a board of directors acted suspiciously to encourage collusion among sellers of goods or services. This issue is of substantial importance and will be recurring because, if allowed, the Commission will continue to use this standard to remove any true burden on the Commission in future antitrust cases.

Finally, the decisions of the Commission and the Fifth Circuit Court of Appeals conflict with the

holding of the Court of Appeals for the Sixth Circuit because they interpret *California Dental* as allowing a quick-look analysis without defining a market, either by the proper analysis, or a finding that the market was sufficiently well-known. This Court should determine which court of appeals has properly interpreted *California Dental* and the requirements of market definition for application of the quick-look standard. This Court should adopt the standard of the Court of Appeals for the Sixth Circuit, which requires proof in a quick-look analysis of a relevant market so that a knowledgeable determination can be made whether or not there is an obvious anticompetitive effect on customers and markets.

The problems created by the analysis set forth by the Commission and affirmed by the court of appeals are real. The Court should allow full briefing of the issues in this case.

CONCLUSION

For these reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

By:

_____

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IN THE UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 06-60023

[FILED, JULY 18, 2008, CHARLES R. FULBRUGE, III, CLERK]

NORTH TEXAS SPECIALTY PHYSICIANS

Petitioner

v.

FEDERAL TRADE COMMISSION

Respondent

AMERICAN MEDICAL ASSOCIATION; TEXAS MEDICAL ASSOCIATION

Amicus Curiaes

Petition for Review of an Order of the Federal Trade Commission

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ON PETITION FOR REHEARING EN BANC

(Opinion May 14, 2008, 5 Cir., _____, _____ F.3d _____ __)

Before KING, WIENER, and OWEN, Circuit Judges.

PER CURIAM:

(✓) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (FED. R. APP. P. and 5th CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

( ) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. The court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor (FED. R. APP. P. and 5th CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

_____

United States Circuit Judge

*Judge Clement and Judge Haynes did not participate in the consideration of the rehearing en banc.

REVISED July 17, 2008

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 06-60023

North Texas Speciality Physicians,

Petitioner,

v.

Federal Trade Commission,

Respondent.

American Medical Association; Texas Medical Association,

Amicus Curiae.

Petition for Review of a Final Order
of the United States Federal Trade Commission

Before KING, WIENER, and OWEN, Circuit Judges.

PRISCI LLA R. OWEN, Circuit Judge:

North Texas Specialty Physicians (NTSP) petitions for review of an opinion and order of the Federal Trade Commission (FTC or Commission) that found certain activities of NTSP constituted horizontal price-fixing unrelated to any procompetitive efficiencies,[1] in violation of section 5 of the Federal Trade Commission Act.[2] We conclude that the FTC's examination, although somewhat abbreviated, of the factual underpinnings of the conduct at issue, its anticompetitive effect, and the procompetitive effects that NTSP claims have occurred or will occur, was adequate, and the FTC's determinations are supported by substantial evidence. However, the remedial order entered by the FTC is overly broad in one respect, and we accordingly grant the petition for review and remand to the Commission so that it may modify its order.

I

NTSP is an organization of independent physicians and physician groups principally located in Tarrant County, which includes the city of Fort Worth, although physicians from seven other Texas counties are affiliated with NTSP. NTSP's size has varied. It had approximately 575 members in 2003 and 480 members in April 2004. As of 2003, NTSP was comprised of practitioners in 26 medical specialties but also included some primary care physicians. The ALJ found, and NTSP does not

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[1] See N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) 75,032 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf.

[2] 15 U.S.C. § 45.

dispute, that in Tarrant County NTSP specialists were a large percentage of the practitioners within a specialty, for example 80 percent in pulmonary disease, 59 percent in cardiovascular disease, and 69 percent in urology. Many NTSP physicians compete with one another. All physicians pay a fee upon joining NTSP and elect representatives from their ranks to serve on its eight-member Board of Directors.

When it formed in 1995, NTSP's original business model was to assemble physician groups and negotiate contracts between these groups and "payors," such as insurance companies, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and partially or fully self-insured employers. These contracts were on a flat fee-per-patient basis and were termed "risk" contracts (also known as "capitation" contracts) because the physician groups bore the risk of profit and loss, based on how efficiently they could provide medical care for the fixed fee per patient during the term of a contract. However, payors' interest in risk contracts declined, and by 2001, NTSP's board began to focus on assisting physicians in negotiating "non-risk" contracts. A non-risk contract is a fee-for-service arrangement between the payor and the physician. The non-risk model was more successful, and at the time of the proceedings before the FTC, NTSP had approximately twenty non-risk contracts and only one risk contract. The FTC found that about one-half of NTSP's physicians participate in the risk contract. Only NTSP's activities with regard to non-risk contracts are at issue. The FTC has not challenged any of NTSP's conduct with regard to risk contracts.

In facilitating non-risk contracts, NTSP and each of its physicians executed Physician Participation Agreements. Those provide that if NTSP enters into an agreement with a payor to disseminate non-risk offers, NTSP will send or "messenger" all of those offers to physicians, who are free to accept or reject them. If more than 50% of the NTSP physicians agree to accept a non-risk offer, NTSP will proceed to negotiate a contract for the physicians. The Physician Participation Agreements contemplate that physicians will not individually pursue a payor offer unless and until they are notified by NTSP that it has permanently discontinued negotiations with that payor. However, the physicians' relationship with NTSP is not exclusive. If NTSP is not negotiating with a payor or if NTSP has an agreement with a payor that does not cover particular services that a physician seeks to provide, a physician may deal directly with that payor or indirectly through participation in other independent physician associations.

NTSP polls its physicians on an annual basis, asking the minimum rate each would accept in a non-risk contract. NTSP uses the poll responses to calculate the mean, median, and mode of the minimum acceptable fees identified by its physicians. Based on these calculations, NTSP determines a minimum contract fee that it utilizes when negotiating managed care contracts on behalf of its participants.[3] NTSP contends that the poll assists it in determining whether a non-risk offer is likely to attract a majority of its participating

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[3] See 2005-2 Trade Cas. (CCH) at 103,460, slip op. at 4.

physicians, and accordingly, it only messengers non-risk contracts that offer at least the minimum fee calculated from the polls.

NTSP reports the mean, median, and mode from the polls to its participating physicians and explains to participating physicians that "NTSP polls its affiliates and membership to establish Contracted Minimums." In conducting the poll each year, NTSP reminds physicians of the results of the previous year's poll.

The FTC issued an administrative complaint alleging that NTSP restrained competition among its physicians through horizontal price-fixing in violation of the FTC Act.[4] NTSP responded that there were "spillover" effects from its and its physicians' experience with risk contracts into its non-risk contracts that resulted in net procompetitive effects. It argued that it trains physicians to work together as more efficient teams and to be more efficient as individual practitioners and that these improvements will "spillover" to non-risk treatment if the same teams of key physicians can continue working together. NTSP cites as an example situations in which a primary-care physician and a specialist have coordinated in treating a certain illness, so that other patients with the same condition benefit and receive higher-quality care. It also asserts that its physicians can, through experience, eliminate unnecessary tests and procedures, lowering the cost of health care.

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[4] 15 U.S.C. § 45(a) (declaring illegal, and giving the FTC the power to prevent, "unfair methods of competition").

The matter was tried before an Administrative Law Judge (ALJ), who found that NTSP's conduct constituted horizontal price-fixing unrelated to any procompetitive justifications and issued a cease and desist order. NTSP appealed to the FTC for a de novo review, and the Commission affirmed.

The Commission concluded that NTSP's conduct constituted concerted action among physicians because it is controlled by physicians, rejecting the argument that NTSP was a sole actor. The FTC concluded that the participating physicians have taken collective action in an attempt to obtain higher fees.[5] Although the FTC concluded that NTSP's "conduct could be characterized as per se unlawful under the antitrust laws, and thus subject to summary condemnation,"[6] the Commission used an "inherently suspect" analysis, citing its prior decision in Polygram Holding, Inc.,[7] and the District of Columbia Circuit's decision affirming the FTC in that case.[8] The FTC rejected NTSP's proffered pro-competitive justifications and entered a cease and desist order against NTSP that, among other provisions, required termination of existing non-risk contracts at the payor's request or at the earliest

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[5] 2005-2 Trade Cas. (CCH) at 103,466, slip op. at 16.

[6] Id. at 103,460, slip op. at 3.

[7] 5 Trade Reg. Rep. (CCH) ¶ 15,453 (F.T.C. 2003), available at http://ftc.gov/os/2003/07/polygramopinion.pdf.

[8] Polygram Holding, Inc. v. FTC, 416 F.3d 29 (D.C. Cir. 2005).

termination or renewal date. NTSP now petitions this court for review of the FTC's opinion and order.

II

NTSP has raised five broad issues on appeal: whether (1) there was concerted action; (2) the FTC could utilize an "inherently suspect" analysis rather than a full-blown rule-of-reason examination and if so, did the Commission ignore undisputed evidence of NTSP's procompetitive justifications; (3) NTSP's right to due process was violated by the denial of discovery regarding procompetitive effects of its conduct; (4) the FTC had jurisdiction; and (5) the FTC's remedial order is overly broad. The FTC's findings "as to the facts, if supported by evidence, shall be conclusive,"[9] even if "suggested alternative conclusions may be equally or even more reasonable and persuasive."[10] We review the FTC's legal analysis and conclusions de novo, "although even in considering such issues the courts are to give some deference to the [FTC]'s informed judgment that a particular commercial practice is to be condemned as 'unfair.'"[11] Constitutional challenges are reviewed de novo.[12]

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[9] 15 U.S.C. § 45(c).

[10] Colonial Stores, Inc. v. FTC, 450 F.2d 733, 739 (5th Cir. 1971).

[11] FTC v. Ind. Fed'n of Dentists, 476 U.S. 447, 454 (1986).

[12] See Soadjede v. Ashcroft, 324 F.3d 830, 831 (5th Cir. 2003).

III

We first consider the jurisdictional issue. NTSP contends that its alleged anticompetitive conduct was not "in or affecting commerce,"[13] because effects on interstate commerce must be "more than de minimis when considered in proportion to the parties' business as a whole," and its conduct "was never shown to have even a de minimis effect on the business of any payor as a whole."

The FTC assumed in the present case that "the definition of 'unfair methods of competition' under the FTC Act, 15 U.S.C. § 45, is the same as the definition of a 'contract combination . . . or conspiracy, in restraint of trade . . . .' under Section 1 of the Sherman Act, 15 U.S.C. § 1,"[14] and at least one circuit court agrees that "the analysis under § 5 of the FTC Act is the same . . . as it would be under § 1 of the Sherman Act."[15] NTSP does not take issue with this interpretation.

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[13] 15 U.S.C. § 45 (declaring unlawful "unfair methods of competition in or affecting commerce" and providing "[t]he Commission is hereby empowered and directed to prevent persons . . . or corporations . . . from using unfair methods of competition in or affecting commerce"); see also id. § 44 (defining "commerce" to include "commerce among the several States").

[14] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032, at 103,463 n.10, slip op. at 9 n.10 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf.

[15] Polygram Holding, Inc. v. FTC, 416 F.3d 29, 32 (D.C. Cir. 2005).

The United States Supreme Court has explained with regard to jurisdiction under the Sherman Act that "because the essence of any violation of § 1 is the illegal agreement itself—rather than the overt acts performed in furtherance of it, proper analysis focuses, not upon actual consequences, but rather upon the potential harm that would ensue if the conspiracy were successful."[16] The Supreme Court elaborated:

> If establishing jurisdiction required a showing that the unlawful conduct itself had an effect on interstate commerce, jurisdiction would be defeated by a demonstration that the alleged restraint failed to have its intended anticompetitive effect. This is not the rule of our cases. A violation may still be found in such circumstances because in a civil action under the Sherman Act, liability may be established by proof of either an unlawful purpose or an anticompetitive effect.
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> Thus, respondent need not allege, or prove, an actual effect on interstate commerce to support federal jurisdiction.[17]

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[16] Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 330 (1991) (internal citations omitted).

[17] Id. at 331 (quoting McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232, 242-43 (1980) (internal citations omitted)).

The Supreme Court has also explained: "Nor is jurisdiction defeated in a case relying on anticompetitive effects by plaintiff's failure to quantify the adverse impact of defendant's conduct."[18] Similarly, the Court has said: "Nor was it necessary for petitioners to prove that the fee schedule raised fees. Petitioners clearly proved that the fee schedule fixed fees and thus 'deprive[d] purchasers or consumers of the advantages which they derive from . . . competition.'"[19]

The FTC reasoned that "NTSP's actions to maintain physician fee levels, if successful, could be expected to affect the flow of interstate payments from out-of-state payors to NTSP physicians."[20] Payors also testified that they provide health-care coverage to national companies with employees in Texas, and that an increase in costs for health-care services in Fort Worth would affect the overall insurance costs of these national companies. If NTSP's efforts to maintain physicians' fees were successful, "as a matter of practical economics,"[21] the advantages of competition have been adversely affected for out-of-state employers and payors. The FTC had jurisdiction.

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[18] McLain, 444 U.S. at 243.

[19] Goldfarb v. Va. State Bar, 421 U.S. 773, 785 (1975) (quoting Apex Hosiery Co. v. Leader, 310 U.S. 469, 501 (1940)).

[20] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032, at 103,462, slip op. at 8 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf.

[21] Summit Health, Ltd., 500 U.S. at 331.

IV

The FTC found that "NTSP is controlled by competing physicians, and therefore is not a sole actor for purposes of the antitrust laws."[22] The Commission "agree[d] with the ALJ's conclusion that NTSP's participating physicians have taken collective action to obtain higher fees from payors."[23]

NTSP maintains that there was no collusion among affiliated physicians and that there was no concerted action. It advances a number of arguments in this regard. In analyzing them, we first note that NTSP has compartmentalized the FTC's findings and holdings. For example, NTSP argues that the FTC held that "a vote taken by a single entity's board of directors not to participate in a payor's offer to physicians satisfies the Sherman Act's conspiracy element." But the FTC's conclusion that there was horizontal price-fixing did not depend on the isolated fact that NTSP's board refused to messenger all offers from a payor to affiliated physicians. The FTC concluded, as we will discuss more fully below, that certain aspects of NTSP's non-risk contract business, when considered on the whole, combined to result in horizontal price-fixing. These practices included the disclosure to all affiliated physicians of the median, mean, and mode results of polls to determine the minimum rates physicians would accept, the "reminder" to physicians of those results when subsequent polls

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[22] 2005-2 Trade Cas. (CCH) at 103,466, slip op. at 16.

[23] Id.

were taken for the purpose of establishing a minimum price, and NTSP's use of that minimum price when it negotiated with payors on behalf of physicians.

NTSP maintains that it is a single entity and that it has a right to refuse to deal with payors without violating the antitrust laws, citing the Supreme Court's decision in United States v. Colgate & Co.[24] NTSP contends that it is a "memberless, non-profit corporation" and that its actions are not the actions of individual physicians.

The FTC correctly discerned that antitrust liability does not depend upon a particular form or business structure. As the FTC pointed out, antitrust law would be easily evaded if illegal joint activity could be transformed into legal unilateral activity through the formation of a single trust or other corporate entity.[25] NTSP's status as a "memberless" organization under state law or as an incorporated legal entity does not foreclose a finding of concerted action by the physicians who constitute, use, and control NTSP. In St. Bernard General Hospital, Inc., we held that a plaintiff stated a claim under § 1 of the Sherman Act by alleging that an insurance provider was an association composed of nine hospitals that effectively controlled the board by choosing a majority of the directors and selecting the "outside" directors.[26] Here, the affiliated

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[24] 250 U.S. 300 (1919).

[25] See 2005-2 Trade Cas. (CCH) at 103,466, slip op. at 15.

[26] St. Bernard Gen. Hosp. v. Hosp. Serv. Ass'n of New Orleans, Inc., 712 F.2d 978, 981, 985 (5th Cir. 1983).

physicians control NTSP in a similar manner through their election of board members and additionally, through their responses to the polls regarding fees. When an organization is controlled by a group of competitors, it is considered to be a conspiracy of its members.[27]

NTSP counters that the physicians on its board are from different medical specialties and do not compete with one another. As the Ninth Circuit observed in Hahn, the correct analysis is not whether the board members compete directly with one another but whether the organization is controlled by members with substantially similar economic interests.[28] Each member of NTSP's board competes with rank-and-file members of the same specialty, and within the rank-and-file, NTSP specialists compete with other practitioners in their specialty, and primary care providers compete with other primary care providers.

NTSP stresses that the ALJ found that no physician agreed with another to reject a non-risk contract offer, there was no consultation among physicians in responding to polls, and no physician knew how another physician would respond to a non-risk offer. NTSP also emphasizes that no physician agreed in advance to accept contract offers that it negotiated, each physician decided whether to accept a payor's offer, and physicians rejected offers

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[27] See United States v. Sealy, Inc., 388 U.S. 350, 352-54 (1967).

[28] Hahn v. Or. Physicians' Serv., 868 F.2d 1022, 1029 (9th Cir. 1988).

messengered through NTSP more than two-thirds of the time. The ALJ and the FTC concluded that in spite of these facts, the physicians had taken collective action in an attempt to obtain higher fees from payors.[29] The FTC reasoned that NTSP's arguments "conflate[] what really are two separate issues," those being "whether parties can enter into an agreement absent direct communication with each other,"[30] and "whether it is possible to find that there was an agreement on price even though individual physicians were not bound to adhere to contract terms negotiated by NTSP."[31]

With regard to the first issue, the FTC reasoned that "it is enough that participating physicians individually authorized NTSP to take certain actions on their behalf, knowing that others were doing the same thing,"[32] noting in particular that "NTSP would inform physicians who had not yet granted it contract negotiation authority but were considering it, the number of other member physicians who had already given NTSP that authority."[33] The record supports this conclusion. Additionally, as discussed above, the physicians granted NTSP the right to negotiate with payors and agreed not to deal with a payor until NTSP advised

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29 2005-2 Trade Cas. (CCH) at 103,466, slip op. at 16.

30 Id.

31 Id. at 103,467, slip op. at 17.

32 Id.

33 Id. at 103,467 n.27, slip op. at 17 n.27.

that negotiations had ended. The physicians knew that other physicians were doing likewise and that negotiations by NTSP were for the physicians' collective benefit on price and other material terms.

We agree with the Commission that the fact that physicians could reject offers negotiated by NTSP does not establish that there was no agreement on price. We will consider the price-fixing issue in more detail below.

NTSP asserts that a trade or professional organization cannot be presumed to violate Section 1 of the Sherman Act, citing this court's decision in Viazis v. American Association of Orthodontists.[34] It contends that the FTC deemed NTSP a "walking conspiracy." However, the FTC's opinion explicitly recognized that a trade association is not necessarily "a 'walking conspiracy,'" citing Viazis, and that collective action by competitors must result in an unreasonable restraint of trade before there is an antitrust violation.[35]

NTSP cites this court's decision in Consolidated Metal Products, Inc. v. American Petroleum Institute,[36] arguing that because its

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[34] 314 F.3d 758, 764 (5th Cir. 2002) ("Despite the fact that 'a trade association by its nature involves collective action by competitors, it is not by its nature a walking conspiracy, its every denial of some benefit amounting to an unreasonable restraint of trade.") (quoting Consol. Metal Prods., Inc. v. Am. Petroleum Inst., 846 F.2d 284, 293-94 (5th Cir. 1988)).

[35] 2005-2 Trade Cas. (CCH) at 103,466, slip op. at 16.

[36] 846 F.2d 284 (5th Cir. 1988).

physicians remained free to reject an offer messengered by NTSP, NTSP's board is acting unilaterally when it contracts with a payor. In Consolidated Metal Products, a trade association that set standards for oil field equipment delayed in certifying that the plaintiff's sucker rods met its standards. Sucker rods could be and were sold without the trade association's seal of certification. This court held that "a trade association that evaluates products and issues opinions, without constraining others to follow its recommendations, does not per se violate section 1 when, for whatever reason, it fails to evaluate a product favorably to the manufacturer."[37] In conducting a rule-of-reason analysis of the association's actions, this court emphasized that the plaintiff "no longer contends that there was an anticompetitive conspiracy between its competitors and [the trade association]."[38] "[i]t is axiomatic that trade standards must exclude some things as substandard and it is unsurprising that standard-setting bodies sometimes err," and the plaintiff "offers no evidence that [the trade association's] product approval program is merely a ploy to obscure a conspiracy against competing producers." The record of NTSP's and its affiliated physicians' activities in this case does not resemble the conduct at issue in Consolidated Metal Products.

At numerous points in its briefing, NTSP invokes the Supreme Court's decision in United

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[37] Id. at 292.

[38] Id. at 293.

States v. Colgate & Co.,[39] contending that as a single entity, it is entitled to refuse to deal with any payor that it chooses and that it could select a minimum price as the starting point in all negotiations with payors. We have recognized that "[n]othing in the antitrust laws prohibits an individual trader, absent an anticompetitive intent, from announcing in advance the terms on which he will deal," citing Colgate.[40] But the Colgate doctrine has no applicability to "[a] joint effort to fix prices."[41] NTSP's right to refuse to deal turns on whether there has been such a joint effort, a subject we consider below in Part VI.

V

NTSP assails the legal framework used by the FTC to determine whether NTSP's structure and activities amounted to an unlawful restraint of trade, notwithstanding the proffered procompetitive justifications. The FTC employed what it termed an "inherently suspect" analysis, citing its prior decision in Polygram Holding, Inc.[42] and the District of Columbia Circuit's opinion affirming the FTC.[43]

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[39] 250 U.S. 300 (1919).

[40] St. Bernard Gen. Hosp., Inc. v. Hospital Serv. Ass'n of New Orleans, Inc., 712 F.2d 978, 986-87 (5th Cir. 1983).

[41] Id. at 987.

[42] 5 Trade Reg. Rep. (CCH) ¶ 15,453 (F.T.C. 2003).

[43] Polygram Holding, Inc. v. FTC, 416 F.3d 29 (D.C Cir. 2005).

NTSP contends that the FTC was required to conduct a more in-depth rule-of-reason analysis, which NTSP asserts should entail defining a relevant market and finding anticompetitive effects before its conduct could be condemned. NTSP further asserts that the FTC "ignored" the procompetitive justifications it advanced and that the Commission did not permit NTSP to prove the procompetitive effects of its non-risk contracting practices.

As noted earlier, the FTC concluded that NTSP's "conduct could be characterized as per se unlawful under the antitrust laws, and thus subject to summary condemnation."[44] The FTC chose, however, to apply its "inherently suspect" analysis, which it described as a "close neighbor[]" to a per se analysis.[45] It gave two reasons for pursuing that course. The first was that "the Supreme Court has urged caution in the application of the per se label to conduct in a professional setting," and "the

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[44] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032, at 103,460, slip op. at 3 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf; see also id. at 103,463, slip op. at 10 ("There is precedent for outright per se condemnation of conduct that parallels the conduct in issue here. . . . Although NTSP's activities could be characterized as per se illegal because they are closely analogous to conduct condemned per se in this and other industries, we will not apply that label here and now in this particular case.").

[45] Id. at 103,460, slip op. at 3.

Commission wants to encourage providers to engage in efficiency-enhancing collaborative activity."[46]

The Commission said that the beginning of its inquiry should be determining whether NTSP had engaged in "'behavior that past judicial experience and current economic learning have shown to warrant summary condemnation.'"[47] The Commission reasoned that "[a]t this [initial] stage, the focus of the inquiry is on the nature [of] the restraint rather than on the market effects in a particular case."[48] It concluded that "[a] defendant can avoid summary condemnation, however, if it can advance a legitimate justification for the practice."[49] The Commission further reasoned that "[t]he defendant need only articulate a legitimate justification, and is not obliged to prove the competitive benefits," explaining in a parenthetical: "[r]emember that the issue at this initial stage is simply whether the practice should be condemned summarily."[50] The FTC concluded that in its "inherently suspect" paradigm, "[t]he proffered justifications . . . must be both cognizable under the

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[46] Id. at 103,464, slip op. at 11 (emphasis in original).

[47] Id. at 103,464, slip op. at 12 (quoting Polygram Holding, Inc., 5 Trade Reg. Rep. (CCH) ¶ 15,453 (F.T.C. 2003)).

[48] Id.

[49] Id.

[50] Id. at 103,464, slip op. at 12-13

antitrust laws and at least facially plausible."[51] And,

> [a] justification is plausible if it cannot be rejected without extensive factual inquiry. . . Although the defendant need not produce detailed evidence at this stage, it must articulate the specific link between the challenged restraint and the purported justification to merit a more searching inquiry into whether the restraint may advance procompetitive goals, even though it facially appears of the type likely to suppress competition.[52]

In reviewing the FTC's decision, our task is to apply the principles articulated by the Supreme Court. It has "analyzed most restraints under the so-called 'rule of reason,'" which "requires the factfinder to decide whether under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition."[53] The Court has recognized the costs and the shortcomings when an "elaborate inquiry into the reasonableness of a challenged business practice" is conducted.[54] However, the "costs of

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[51] Id. at 103,464, slip op. at 13.

[52] Id. at 103,465, slip op. at 13 (quoting Polygram Holding, Inc. v. FTC, 416 F.3d 29, 31-32 (D.C. Cir. 2005)).

[53] Arizona v. Maricopa County Med. Soc., 457 U.S. 332, 343 (1982).

[54] Id.

judging business practices under the rule of reason . . . have been reduced by the recognition of per se rules."[55] "Once experience with a particular kind of restraint enables the Court to predict with confidence that the rule of reason will condemn it, it has applied a conclusive presumption that the restraint is unreasonable."[56] Practices that are per se unlawful include "price fixing, division of markets, group boycotts, and tying arrangements."[57] The per se rules can result in erroneous conclusions in some cases, but "[f]or the sake of business certainty and litigation efficiency, we have tolerated the invalidation of some agreements that a fullblown inquiry might have proved to be reasonable."[58] Procompetitive justifications will not be considered if a practice, such as price-fixing, is a per se violation. "The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some."[59]

The Supreme Court has recognized, however, that even when practices are not condemned by a per se rule, a fullblown rule-of-reason analysis is not

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[55] Id. at 343-44.

[56] Id. at 344.

[57] Id. at 344 n.15 (citing N. Pac. R. Co. v. United States, 356 U.S. 1, 5 (1958)).

[58] Id. at 344.

[59] Id. at 351.

always required.[60] An "abbreviated or 'quick-look' analysis under the rule of reason" is appropriate when an "observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect on customers and markets."[61] Stated another way, "quick- look analysis carries the day when the great likelihood of anticompetitive effects can easily be ascertained."[62] The "inherently suspect" paradigm that the FTC employed in the present case is a "quick-look" rule-of-reason analysis.

But a "quick-look" examination is not a rigid template. It must be tailored to fit the circumstances presented in each case. The Supreme Court explained in California Dental Association that "[t]he truth is that our categories of analysis of anticompetitive effect are less fixed than terms like

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[60] See, e.g., Texaco, Inc. v. Dagher, 547 U.S. 1, 7 n.3 (2006) ("To be sure, we have applied the quick look doctrine to business activities that are so plainly anticompetitive that courts need undertake only a cursory examination before imposing antitrust liability.").

[61] Cal. Dental Ass'n v. FTC, 526 U.S. 756, 770 (1999).

[62] Id. (citing Law v. National Collegiate Athletic Ass'n, 134 F.3d 1010, 1020 (10th Cir. 1998), for the proposition that "quick-look analysis applies 'where a practice has obvious anticompetitive effects,'" and Chicago Prof'l Sports Ltd. P'ship v. National Basketball Ass'n, 961 F.2d 667, 674-76 (7th Cir. 1992), for "finding quick-look analysis adequate after assessing and rejecting logic of proffered procompetitive justifications").

'per se,' "quick look,' and 'rule of reason' tend to make them appear."[63] The Court continued:

> We have recognized, for example, that "there is often no bright line separating per se from Rule of Reason analysis," since "considerable inquiry into market conditions" may be required before the application of any so-called "per se" condemnation is justified. "[W]hether the ultimate finding is the product of a presumption or actual market analysis, the essential inquiry remains the same—whether or not the challenged restraint enhances competition."[64]

The California Dental Association decision directs us to conduct "an enquiry meet for the case, looking to the circumstances, details, and logic of a restraint":

> [T]here is generally no categorical line to be drawn between restraints that give rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment. What is required, rather, is an enquiry meet for the case, looking to the circumstances, details, and logic of a restraint. The object is to see whether the experience of the market has been

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[63] Id. at 779.

[64] Id. at 779-80 (internal citations omitted) (quoting Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of the Univ. of Okla., 468 U.S. 85, 104 & n.26 (1984)).

> so clear, or necessarily will be, that a confident conclusion about the principal tendency of a restriction will follow from a quick (or at least quicker) look, in place of a more sedulous one. And of course what we see may vary over time, if rule-of-reason analyses in case after case reach identical conclusions. For now, at least, a less quick look was required for the initial assessment of the tendency of these professional advertising restrictions. Because the Court of Appeals did not scrutinize the assumption of relative anticompetitive tendencies, we vacate the judgment and remand the case for a fuller consideration of the issue.[65]

The FTC formulated its "inherently suspect" analysis after the issuance of California Dental Association, and the Commission's articulation of the shifting burdens employed in its analysis appears, at least facially, to comport with the framework provided by the Supreme Court's precedent.[66] Reviewing courts must be attentive, however, to the actual application of the burden-shifting.

In California Dental Association, the Supreme Court faulted the court of appeals for describing the anticompetitive effects of the conduct under scrutiny

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[65] Id. at 780-81.

[66] See also Polygram Holding, Inc. v. FTC, 416 F.3d 29, 35-36 (D.C. Cir. 2005).

in a cursory and conclusory manner,[67] and for failing to "identif[y] the theoretical basis for the anticompetitive effects and [to] consider[] whether the effects actually are anticompetitive."[68] The need to determine, as an initial point of departure, whether the practice at issue theoretically has anticompetitive effects is important, indeed paramount, because "quick-look analysis in effect requires" "shifting to a defendant the burden to show empirical evidence of procompetitive effects."[69] The Court made clear that "before a theoretical claim of anticompetitive effects can justify shifting to a defendant the burden to show empirical evidence of procompetitive effects, . . . there must be some indication that the court making the decision has properly identified the theoretical basis for the anticompetitive effects and considered whether the effects actually are anticompetitive."[70] The Supreme Court admonished that if "the circumstances of the restriction are somewhat complex, assumption alone will not do."[71] The Court emphasized in California Dental Association that "the [Court of Appeals'] adversion to empirical evidence at the moment of this implicit burden shifting underscores the

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67 Cal. Dental Ass'n, 526 U.S. at 774 ("But these observations brush over the professional context and describe no anticompetitive effects.").

68 Id. at 775 n.12.

69 Id.

70 Id.

71 Id.

leniency of its enquiry into evidence of the restrictions' anticompetitive effects."[72]

In the case before us, the FTC did not rely on empirical evidence in determining whether there was an "obvious anticompetitive effect that triggers abbreviated analysis."[73] It relied on the theoretical basis for the anticompetitive and procompetitive effects of NTSP's challenged practices and the similarity of those practices to conduct that would be a per se violation of the FTC Act. To some extent, the Commission also relied on evidence of the impact of NTSP's conduct on some payors. The FTC concluded that "the determination of illegality here does not require an elaborate inquiry into effects in the market.[74]

We, like the FTC, do not decide whether NTSP's challenged practices constituted a per se violation, although we agree that some of NTSP's practices bear a very close resemblance to horizontal price-fixing, generally deemed a per se violation. Quick-look analysis rather than a more searching rule-of-reason inquiry is appropriate only when "the likelihood of anticompetitive effects is . . . obvious," meaning "when the great likelihood of anticompetitive effects can easily be ascertained," and "after assessing and rejecting [the] logic of

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[72] Id. at 776.

[73] Id. at 778.

[74] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032, at 103,460, slip op. at 3 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf.

proffered procompetitive justifications."[75] To justify a quick-look analysis, the burden remains on the challenger to demonstrate that the proffered procompetitive effect does not plausibly result in "a net procompetitive effect, or possibly no effect at all on competition."[76] If, after examining the competing claims of anti-and procompetitive effects, it remains plausible that the net effect is procompetitive or that there is no effect on competition,[77] then "[t]he obvious anticompetitive effect that triggers abbreviated analysis has not been shown.[78]

As will be considered in detail below, we conclude that the net anticompetitive effects of certain of NTSP's practices were obvious. The procompetitive justifications do not plausibly result in a net procompetitive effect or in no effect at all on competition. Accordingly, a quick-look analysis was appropriate in this case.

VI

The FTC's ultimate conclusion was that the "activities [of NTSP], taken as a whole, amount to horizontal price fixing which is unrelated to any

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[75] Cal. Dental Ass'n, 526 U.S. at 770-71 (citing Law v. Nat'l Collegiate Athletic Ass'n, 134 F.3d 1010, 1020 (10th Cir. 1998); Chicago Prof] Sports Ltd. P'ship v. Nat'l Basketball Ass'n, 961 F.2d 667, 674-76 (7th Cir. 1992)).

[76] Id. at 771.

[77] Id. at 771.

[78] Id. at 778.

procompetitive efficiencies."[79] In deciding "whether NTSP's conduct amounts to a restraint of trade," the Commission said that it would first "look at the factual evidence to determine whether the conduct amounts to price fixing, and is thus illegal absent a cognizable and plausible justification."[80] In Part A below we consider "the theoretical basis for the anticompetitive effects" of NTSP's conduct and whether "the effects actually are anticompetitive."[81] We consider in Part B whether NTSP's proffered justifications might plausibly be thought to have net procompetitive effects.

A

The first challenged restraint the FTC examined was polls of participating physicians that NTSP conducted.[82] NTSP asked each physician what minimum rate or fee he or she would be willing to accept during the coming year. The FTC found as factual matters that NTSP then reported the mean, median, and mode of the responses to all affiliated physicians, and those physicians were aware that NTSP would determine a minimum fee for its negotiations with payors from the poll responses.[83]

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[79] 2005-2 Trade Cas. (CCH) at 103,460, slip op. at 3.

[80] Id. at 103,467, slip op. at 17.

[81] Cal. Dental Ass'n v. FTC, 526 U.S. 756, 775 n.12 (1999).

[82] 2005-2 Trade Cas. (CCH) at 103,467, slip op. at 18.

[83] Id.

NTSP also reminded its physicians of the prior poll's results in soliciting each physician to state the minimum fee he or she would accept during the upcoming year. The FTC reasonably concluded that the "physicians anticipated that any individual response would help to raise or lower the average fee for the group—an average that NTSP would then use in negotiating with payors."[84]

The written Physician Participation Agreement NTSP had with each physician obligated the physician to refrain from pursuing an offer from a payor if NTSP was in negotiations with that payor.[85] This either foreclosed or delayed negotiations between those payors and physicians who were willing to accept a fee lower than the minimum fee determined by NTSP and used in its negotiations with payors. If NTSP was successful in obtaining a contract with a payor, it is logical to conclude that the fees to which NTSP agreed would be higher than the minimum fees that many of its participating physicians were willing to accept and had indicated in their polling responses they were willing to accept. The FTC relied on an expert's conclusions that "the NTSP minimum reimbursement rates were higher than what some physicians were actually willing to accept, and that negotiation of a minimum price offer has the effect of raising the prices that 'low end' physicians would otherwise earn, without reducing the price that 'high end' physicians would receive" because the "high

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[84] Id.

[85] See id. at 103,468, slip op. at 20.

end" physicians could "opt out."[86] These conclusions are logical and are supported by the record. If NTSP did not consummate a contract with a payor in its negotiations, then that payor's ability to bargain directly with physicians was delayed. Payors' patients in need of medical services did not have access to NTSP physicians while negotiations were ongoing, and accordingly, the number of competing physicians was reduced.

NTSP disputes the FTC's construction of the Participating Physician Agreements with physicians, contending that those contracts do not require physicians to await notice from NTSP that negotiations with a payor have ceased before a physician may negotiate directly with that payor. The contracts do not support this argument. Section 2 of the physician agreement deals with payor offers. It provides in subsection 2.1 that "NTSP shall have the right to receive all Payor Offers made to NTSP or Physician," and the physician is obligated to "promptly forward such Payor Offer to NTSP for further handling." There is an exception for offers that are to extend or renew an existing contract between the physician and the payor.[87] Otherwise,

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[86] Id. at 103,468, slip op. at 19.

[87] Subsection 2.1 provides in its entirety:

> Receipt of Payor Offers. NTSP shall have the right to receive all Payor Offers made to NTSP or Physician, except for any Payor Offer made to Physician which is solely in replacement or renewal of a contract which exists between such Payor and Physician as of the date of March 1, 1998. If Physician receives a Payor Offer (other than a Payor Offer made to Physician which is

it is only if NTSP rejects a payor offer that a physician has "the right to pursue such Payor Offer on its own behalf."[88] The agreements have a "non-exclusivity" clause, but it reiterates that physicians may not negotiate directly with payors concerning services covered by a payor offer or an existing NTSP agreement.[89] The non-exclusivity clause recognizes

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solely in replacement or renewal of a contract which exists between such Payor and physician as of the date of March 1, 1998), Physician will promptly forward such Payor Offer to NTSP for further handling in accordance with the provisions of this Agreement.

[88] Subsection 2.6 provides:

> Payor Offers Rejected by NTSP. If NTSP rejects any Payor Offer and advises the Participating Physicians in writing that it is permanently discontinuing negotiations or if the Participating Physicians who approved and who are deemed to have approved a Non Risk Payor Offer constitute less than 50% of all Participating Physicians, then NTSP shall have no further responsibilities with respect thereto and any Participating Physician shall have the right to pursue such Payor Offer on its own behalf.

A "Payor Offer" is defined as "an offer made by a Payor to NTSP or Participating Physician that requires NTSP or one or more Participating Physicians to provide covered services pursuant to a commercial or medicare health benefit plan."

[89] Subsection 8.1 provides:

> Non-Exclusivity. Subject to the provisions of Section 2 above, Physician shall be free to (i) negotiate separate contracts directly with payors for services not covered by any Payor Offer or Payor Agreement and to provide on an

that physicians may contract with other physician groups, but only "[s]ubject to Section 2" of the NTSP agreement.[90]

NTSP asserts that even if we agree with the FTC's construction of the physician agreements, there is no evidence that any physician actually refused to negotiate with a payor while NTSP negotiations with that payor were ongoing. The FTC found to the contrary, and there is evidence from payors that physicians declined to negotiate because they had designated NTSP as their bargaining agent.

NTSP points out that only 34 percent of its physicians responded to its polls. The FTC concluded, however, that the fact that poll results were disclosed to all NTSP physicians, regardless of whether they responded to the poll, encouraged physicians "to reject price offers below the minimum fees indicated."[91] It is not obvious that this is the case as to all physicians affiliated with NTSP. Physicians who had expressed an unwillingness to

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individual basis any medical services not subject to a Payor Agreement to any Beneficiary and (ii) provide medical services of any type to any patient who is not covered under any Payor Agreement. Subject to Section 2 above, Physician may contract with other independent practice associations, physician hospital organizations, preferred provider organizations and other managed care provider networks.

[90] See id.

[91] 2005-2 Trade Cas. (CCH) at 103,468, slip op. at 20.

contract at fees below NTSP's minimum might not have been influenced by learning of NTSP's minimum negotiating fee. Those physicians may have rejected price offers below NTSP's minimum in any event. But it is obvious that the practice of reporting poll results encouraged other physicians to reject offers that equaled the fee they reported in the poll as the minimum they would have accepted if the offered fee was less than the minimum fee calculated by NTSP. Armed with knowledge from NTSP's polling, those physicians would also be encouraged to hold out for a fee equal to or even less than NTSP's minimum fee but greater than the fee they were willing to accept at the time they responded to the poll.

The FTC further found that "NTSP actively encouraged [physicians] to reject the offers" below the minimum fees indicated in the polls.[92] That finding is supported by the record and is evidence of concerted action to fix prices.

The record evidence supports the FTC's factual finding that NTSP "regularly informed payors that its physicians had established minimum fees for NTSP-payor agreements, identified the fee minimums, and stated that NTSP would not enter into or forward to any of its physicians payor offers that were below the minimums."[93] There was evidence that after receiving this information, payors attempted to deal directly with individual physicians but were told by those physicians that

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[92] Id.

[93] Id.

they must negotiate with NTSP. The logical tendency of this practice, coupled with the physicians' agreement to refrain from negotiating with payors, was at a minimum to delay direct negotiations between payors and physicians, including physicians willing to accept fees lower than the minimum used by NTSP. This added significant transaction costs to offers below NTSP's minimum. A payor wishing to achieve a contract below that minimum would have to submit its offer to NTSP, negotiate with NTSP, and wait until NTSP communicated to physicians that negotiations were unsuccessful, before being able to negotiate with physicians directly. Accordingly, even though NTSP could not bind physicians to particular contracts, its practices interfered with payors seeking lower fees. NTSP's practices also narrowed patients' choices of physicians.

The FTC additionally found, based on the record evidence, that although the Participating Physician Agreements require NTSP to deliver certain payor offers to physicians,[94] NTSP in fact "rejects and does not deliver any contract that falls below its minimum reimbursement schedule."[95] This prevented or at least delayed offers less than NTSP's minimum fee from reaching physicians.

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[94] Section 2.2 of the Participating Physician Agreements covers "Offers to be Accepted or Rejected by Physicians," a category of payor offers defined separately from other payor offers.

[95] 2005-2 Trade Cas. (CCH) at 103,169, slip op. at 21.

The agreements NTSP had with physicians further "contain[] provisions whereby 50 percent of NTSP's membership must approve the reimbursement proposal of a payor before an offer is 'messengered' by NTSP to the physicians for actual opt-in/out [on an individual basis] of the proposed contracts."[96] This provision allows NTSP to counter payor rate proposals on direction from at least 50 percent of its physicians. The FTC concluded that

> NTSP is able to exert collective bargaining power and hence fix prices because NTSP does not messenger contracts below its minimum reimbursement schedule. Instead it rejects the contracts outright on behalf of its physicians and NTSP's collective bargaining leverage is thus exerted before its physicians even have a chance to opt in or out of a contract.[97]

Here again, it is obvious that when NTSP is successful in negotiating with a payor, the fees in those contracts would tend to be higher than fees many participating physicians otherwise would have been willing to accept, since a significant number of physicians had previously indicated in polling they would be willing to accept less than the mean, median, or mode on which NTSP's minimum negotiating fee was determined.

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[96] Id.

[97] Id.

Another challenged practice is NTSP's use of powers of attorney from its physicians. The FTC found that in negotiations with Aetna, NTSP sent Aetna a list of 180 physicians who had executed powers of attorney appointing NTSP as the bargaining agent for any direct contracting with Aetna.[98] Aetna officials testified that they understood this as a message that the physicians would not negotiate directly, and Aetna concluded there was no practical alternative other than to deal with NTSP.[99]

NTSP contends that the powers of attorney only authorized NTSP to act "in any lawful way." However, in obtaining the powers of attorney, NTSP advised physicians that it would pursue a contract "that meets or exceeds the fee schedule minimums set by the NTSP membership." NTSP did in fact negotiate with payors on behalf of physicians regarding the fees that would be paid.

The FTC further concluded that NTSP had engaged in concerted withdrawals and refusals to deal except on collective terms. The FTC pointed to NTSP's termination of contracts United Healthcare Services, Inc. had with 101 physicians when NTSP was dissatisfied with negotiations.[100] The ALJ's findings in this regard and the facts in the record reflect that United then attempted to negotiate directly with NTSP physicians, they refused, and

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98 Id. at 103,469, slip op. at 22.

99 Id.

100 Id. at 103,469-70, slip op. at 22.

United ultimately offered NTSP higher reimbursement rates.[101]

In another instance cited by the FTC,[102] the ALJ's findings and facts in the record reflect that NTSP had a contract with Cigna that applied to physicians who were specialists.[103] NTSP demanded that its primary care physicians be permitted to "participate" in this contract.[104] Cigna already had contracts with most of these primary care physicians at lower rates.[105] NTSP threatened contract termination if its demands were not met,[106] and to avoid losing the participation of NTSP's specialists, Cigna agreed to NTSP's demands.[107]

At several points in its briefing, NTSP stresses that the FTC and the ALJ found that NTSP did not receive higher rates than those that other

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101 N. Tex. Specialty Physicians, 2004 WL 3142857, slip op. at 22-25, 27-29 (F.T.C. Nov. 15, 2004) (ALJ's Initial Decision), available at http://ftc.gov/os/adjpro/d9312/041116initialdecision.pdf; Transcript of trial before ALJ at 345-48, 443-44, 454-55, 459-60, N. Tex. Specialty Physicians, 2004 WL 3142857 (F.T.C. Nov. 15, 2004) (Docket No. 9312) [hereinafter Tr.].

102 2005-2 Trade Cas. (CCH) at 103,470, slip op. at 23.

103 2004 WL 3142857, slip op. at 32-33.

104 Id. at 35.

105 Id. at 35; Tr. at 718-19, 733-34.

106 2004 WL 3142857, slip op. at 36.

107 Id.; Tr. 749-51.

physicians and physician groups were already receiving. The FTC addressed this fact, saying "[w]e agree that higher physician rates, by themselves, are of no antitrust significance," but the Commission concluded that "this case is about a concerted effort by NTSP's participating physicians to increase their bargaining power."[108] We agree that proof of higher fees for NTSP physicians is not necessary in this case. As the Supreme Court explained in FTC v. Indiana Federation of Dentists, if a practice "is likely enough to disrupt the proper functioning of the price-setting mechanism of the market . . . it may be condemned even absent proof that it resulted in higher prices."[109] In that case dentists had agreed not to send dental x-rays to their patients' insurance companies for use in benefits determinations. The Supreme Court held this was an unfair method of competition in violation of section 5 of the Federal Trade Commission Act.[110] NTSP's challenged

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[108] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032, at 103,477, slip op. at 36-37 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf.

[109] 476 U.S. 447, 461-62 (1986).

[110] Id. at 448-49, 461-62 (explaining more fully that "[a] concerted and effective effort to withhold (or make more costly) information desired by consumers for the purpose of determining whether a particular purchase is cost justified is likely enough to disrupt the proper functioning of the price-setting mechanism of the market that it may be condemned even absent proof that it resulted in higher prices or, as here, the purchase of higher priced services, than would occur in its absence. [E]ven if . . . the costs of evaluating the information were far greater than the cost savings resulting from its use [] the Federation would still not be justified in deciding on behalf of its members' customers that they did not need the information: presumably, if that were the case, the discipline

practices erect barriers between payors and physicians who would otherwise be willing to negotiate directly with those payors. It also erects obstacles to price communications between payors and physicians. The Commission concluded, and we agree, that NTSP engaged in concerted action to increase its bargaining power. The fact that there is no evidence in the record that NTSP obtained higher prices for its physicians than other physicians received does not foreclose a determination that NTSP's practices had anticompetitive effects.

The other side of the equation, however, is the procompetitive effects, if any, that NTSP's challenged business practices generated. We turn to those.

B

After concluding that NTSP's challenged conduct had anticompetitive effects, the FTC proceeded to examine NTSP's justifications. Although the general thrust of NTSP's arguments regarding "spillover" benefits has some facial plausibility, closer examination of the underpinnings of the justification reveals significant gaps in logic.

The FTC first considered the polling of physicians. The Commission reasoned, and we agree, that NTSP's argument that its polls permitted it to determine when spillover efficiencies from risk contracts to non-risk contracts were likely to occur

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of the market would itself soon result in the insurers' abandoning their requests for x rays. The Federation is not entitled to pre-empt the working of the market by deciding for itself that its customers do not need that which they demand.").

did not withstand scrutiny. Of the 34 percent of NTSP physicians responding to the poll, only 55 percent were physicians who participated in NTSP's risk contract. Accordingly, the mean, median, and mode that NTSP determined and used to negotiate with payors was based on minimum acceptable fees from non-risk as well as risk panel physicians. These polling results would not be a particularly effective tool to determine the fee that would attract a majority of NTSP's risk panel physicians, particularly since NTSP did not know which poll responses came from risk as distinguished from non-risk panel physicians. This undercuts a logical nexus to claimed efficiencies and thus the plausibility of the proffered procompetitive effects.

The Commission also recognized that it was not evident how physicians who enter only non-risk contracts could achieve spillover efficiencies from NTSP's risk contract, and NTSP did not offer an explanation. As the FTC correctly noted, "[t]his is a non-trivial point, because non-risk physicians make up half of NTSP's members."[111] This means that half of NTSP physicians had no experience in teamwork with NTSP physicians on the risk panel. Additionally, NTSP had only one risk contract, and it was a small part of NTSP's business. The FTC made further observations supported by the evidence:

> NTSP does not even explain why its risk panel physicians will have the incentive to apply the quality and cost

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[111] 2005-2 Trade Cas. (CCH) at 103,473, slip op. at 30.

> control techniques they utilize on risk patients to any non-risk patients they may have.
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> NTSP has not provided any financial incentive for them to do so, and it does nothing to promote compliance with whatever techniques have been learned under risk contracts. NTSP does not employ the processes it uses to monitor and control the quality and utilization of services provided under its risk contracts to patient care provided under non-risk contracts.[112]

NTSP argues that it did offer some empirical evidence but that the Commission "ignored" it. There is some evidence in the record of spillover effects from the risk contract to non-risk panels, and there is evidence that NTSP physicians perform as well or better than non-NTSP groups. For example, an NTSP expert opined that there is some reason to believe that "what NTSP learns in its risk contracting accrues to the benefit of payors even in the nonrisk setting" and that there are "palpable and real," "beneficial" effects from NTSP's business model. NTSP's expert pointed out that patient data created in a risk setting is available to physicians treating similar patients under a non-risk contract, "disease management and patient education programs" have benefits that spill over to treatment of patients under non-risk contracts, and NTSP's website allows patients and potential payors to see

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[112] Id. (record citations omitted).

performance and quality data for NTSP and other Dallas or Fort Worth area physicians.

We assume that all of the foregoing is factually correct. But, as the FTC importantly noted, NTSP "does not address how [its] nebulous 'teamwork' efficiencies are dependent on its price-fixing activities."[113] NTSP has no theory as to how its proffered procompetitive effects, which we will assume are higher quality healthcare provided by teamwork and shared experiences over time, result from or are in any way connected to (1) communicating the polling results regarding fees to all NTSP physicians, (2) encouraging NTSP physicians to reject payor offers below the minimum fees NTSP calculated from the polls, or (3) using collective bargaining power to demand higher fees for physicians who are already under contract with a payor.

We recognize that the Supreme Court has said that the "'public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.'"[114] But NTSP has not cogently articulated how "the quality of the professional

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[113] Id. at 103,474 n.45, slip op. at 30 n.45.

[114] Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 687 (1978) (quoting Goldfarb v. Va. State Bar, 421 U.S. 773, 788-89 n.17 (1975)).

service that [its] members provide is enhanced by the price restraint."[115]

NTSP offered three other "justifications" for its challenged conduct. The first is that it had "no legal obligation to participate in, messenger, or facilitate a payor's contract offer," and as "a collection of individuals" the group had the right to vote among themselves "not to involve" the group in a contract. NTSP argues that it did not have a significant market share and "that even a monopolist has a right to refuse to deal." This is re-argument of issues relating to an agreement and concerted action, which we have addressed earlier.

The second justification NTSP offers is that it "need[ed] to avoid expending scarce resources in analyzing, messengering, and participating in contracts of interest to relatively few of the physicians." We do not disagree that this is a permissible goal, but this does not justify the challenged methods NTSP used to achieve that goal.

The third justification was "the avoidance of legally or medically risky situations" and that NTSP was "surely justified in refusing to sign payor contracts that present these problems." These are certainly permissible goals. But again, none of these concerns had any bearing on the methods NTSP used in an attempt to obtain higher fees than its physicians might otherwise have been offered.

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[115] Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332, 349 (1982).

One of NTSP's chief complaints is that it was not permitted to develop a fuller record, based on additional empirical evidence. However, it does not assert that the additional empirical evidence it desired to develop would have shown a nexus between better or market-priced medical care and the need for NTSP to engage in the specific activities that we conclude are anticompetitive, which include (1) the communication of the mean, median, and mode results from the polling regarding fees, in combination with (2) foreclosing or delaying direct negotiations between payors and physicians; (3) urging physicians to reject fee offers from payors; and (4) using collective bargaining power to demand higher fees for physicians who were already under contract at a lower fee.

In sum, based on the record in this case, we conclude that "the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency"[116] of NTSP's challenged practices follows from the "look" the FTC conducted in this case, even though that "look" was less than a fullblown market analysis. "[T]he inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition."[117] NTSP's proffered procompetitive effects do not meet the "might plausibly be thought to have a net procompetitive effect, or possibly no

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[116] Cal. Dental Ass'n v. FTC, 526 U.S. 756, 781 (1999).

[117] Nat'l Soc'y of Prof'l Eng'rs, 435 U.S. at 691.

effect at all on competition" threshold.[118] The Commission's determination that NTSP's conduct, taken as a whole, amounted to horizontal price-fixing that is unrelated to procompetitive efficiencies is supported by the law and substantial evidence.

VII

NTSP maintains that its right to due process was violated because it was denied discovery that would have proven the procompetitive effects of its conduct. NTSP subpoenaed the "flat file data" from six insurance company payors, each of which objected to providing the information. NTSP explains that "flat file data" would reflect "medical expenses paid for each patient and can be analyzed to compare different physicians' expense 'per unique patient seen' by procedure, by diagnostic code, and numerous other factors." NTSP contends that from this data, it could prove how its performance on non-risk contracts "compares to that of other physicians." After conducting a hearing, the ALJ quashed the subpoenas.

> In reviewing the ALJ's decision, FTC reasoned:
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> In the absence of a specific link between the challenged restraints and the purported justification, it would not have mattered if [NTSP] had been able to obtain further discovery and demonstrate that its physicians performed well. There is no antitrust

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[118] See Cal. Dental Ass'n, 526 U.S. at 771.

> exemption for more efficient, higher quality market participants, absent a demonstration that the challenged practices made an essential contribution to these efficiencies. Evidence on the performance of NTSP physicians, standing alone, would not prove that nexus.[119]

NTSP contends that our review of this determination is de novo since NTSP is claiming a due process violation. Even assuming that is the correct standard of review, there was no due process violation. There is no logical nexus between better performance by NTSP physicians and NTSP's dissemination of polling results or its other challenged practices that we have discussed above.[120]

VIII

Finally, NTSP challenges the breadth of the Commission's remedial order. Once the FTC has established a violation of the FTC Act, it "has wide discretion in determining the type of order that is

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[119] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) 75,032, at 103,475, slip op. at 32-33 (F.T.C. 2005), available at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf (citations omitted).

[120] See Nat'l Soc'y of Prof'l Eng'rs, 435 U.S. at 693-94 ("The Society nonetheless invokes the Rule of Reason, arguing that its restraint on price competition ultimately inures to the public benefit by preventing the production of inferior work and by insuring ethical behavior. As the preceding discussion of the Rule of Reason reveals, this Court has never accepted such an argument.").

necessary to cope with the unfair practices found."[121] The FTC's order should not be disturbed "unless the remedy selected has no reasonable relation to the unlawful practices found to exist."[122] We are persuaded, however, that the remedy is overly broad in one respect.

The remedial order provides in Part II.A:

> IT IS FURTHER ORDERED that Respondent, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services . . . cease and desist from:
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> A. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians with respect to their provision of physician services:
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> 1. to negotiate on behalf of any physician with any payor;

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[121] FTC v. Colgate-Palmolive Co., 380 U.S. 374, 392 (1965).

[122] Alterman Foods, Inc. v. FTC, 497 F.2d 993, 997 (5th Cir. 1974) (quotation marks omitted).

2. to deal, refuse to deal, or threaten to refuse to deal with any payor;
3. regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms; or
4. not to deal individually with any payor, or not to deal with any payor through any arrangement other than Respondent . . .

While we do not accept many of NTSP's arguments regarding this section of the order, NTSP's contention that subsection (A)(2) is overly broad and internally inconsistent has merit. The ALJ refused to include such a provision, recognizing that it "could have the effect of compelling Respondent to messenger contracts or become a party to contracts sent to it by payors, regardless of potential risks to Respondent, its member physicians, and its patients."[123] This observation is valid. It is also difficult to see how NTSP can both deal and refuse to deal with any payor.

NTSP also challenges Paragraph IV of the order, which requires cancellation of all existing non-

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[123] N. Tex. Specialty Physicians, 2004 WL 3142857, slip op. at 89 (F.T.C. Nov. 15, 2004) (ALJ's Initial Decision), available at http://ftc.gov/os/adjpro/d9312/041116initialdecision.pdf.

risk contracts with payors. These cancellations are to take place at the earlier of receipt of a written request from a payor to terminate or the earliest termination or renewal date, even though payors may elect to continue the contracts for up to one year. This latter provision eliminates NTSP's concern that health care delivery will be interrupted.

NTSP asserts that payors should be permitted to decide if they want to terminate their contracts. However, the FTC reasonably concluded that if the contract termination provisions were voluntary, payors might be unwilling to terminate, fearing reprisal.

NTSP also argues that its freedom of speech is being violated because it is limited in the information it can provide to payors and employers. In the commercial context, speech concerning unlawful activity is not protected.[124] In this case, NTSP's speech is limited only to the extent that it may not further illegal horizontal price-fixing conspiracies. The FTC's order does not unreasonably limit any protected speech by NTSP.

Finally, NTSP claims that the order is impermissibly vague. NTSP asserts that it cannot determine whether all individual components of its activity, such as polling and the Physician Participation Agreement, are prohibited permanently, or might properly be used in the future. We view such claims with skepticism.[125] As

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[124] See Greater New Orleans Broad. Ass'n, Inc. v. United States, 527 U.S. 173, 183 (1999).

[125] See Alterman Foods, 497 F.2d at 1001-02.

the Supreme Court stated, the FTC "must be allowed effectively to close all roads to the prohibited goal" of combinations that unreasonably restrain trade.[126] The FTC need not describe every combination of circumstances and behaviors that may or may not create a violation. The FTC's order is not unreasonably vague or overly broad.

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For the reasons stated above, we GRANT petitioner's request for review and REMAND this proceeding to the FTC for modification of subsection II.A.2 of the remedial order in a manner consistent with this opinion.

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[126] See FTC v. Ruberoid Co., 343 U.S. 470, 473 (1952).

In the Matter of North Texas Specialty Physicians, a corporation
Docket No. 9312

OPINION OF THE COMMISSION

By LEARY, Commissioner, For A Unanimous Commission:

I. Introduction

This case involves the question of whether an independent physician association's contracting activities with payors amounts to unlawful horizontal price fixing, or is competitively benign activity that may enhance efficiency and innovation in the delivery of health care. The Commission has accepted numerous consent orders over the last ten years involving conduct similar to that at issue in the case at hand.[1] The common theme of these cases

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[1] *See, e.g., In the Matter of San Juan IPA, Inc.*, Docket No. C-4142 (consent order issued June 30, 2005), http://www.ftc.gov/opa/2005/07/fyi0548.htm; *In the Matter of New Millennium Orthopaedics, LLC*, Docket No. C-4140 (consent order issued June 13, 2005), http://www.ftc.gov/opa/2005/06/fyi0543.htm; *In the Matter of White Sands Health Care System, L.L.C.*, Docket No. C-4130 (consent order issued Jan. 11, 2005), http://www.ftc.gov/opa/2005/01/fyi0504.htm; *In the Matter of Piedmont Health Alliance, Inc.*, Docket No. 9314 (consent order issued Oct. 1, 2004), http://www.ftc.gov/opa/2004/10/fyi0457.htm; *In the Matter of Southeastern New Mexico Physicians IPA, Inc.*, Docket No. C-4113 (consent order issued Aug. 5, 2004), http://www.ftc.gov/opa/2004/08/fyi0445.htm; *In the Matter of California Pacific Medical Group, Inc.*, Docket No. 9306 (consent order issued May 10, 2004), http://www.ftc.gov/opa/2004/05/fyi0431.htm.

has been coordinated bargaining by groups of competing physicians, in order to increase their reimbursement rates. In these cases, competing physicians have often joined together in independent practice associations (IRAs, or networks) and agreed to boycott or refuse to deal with particular payors during contract negotiations. When the competing physicians are not financially or clinically integrated in a manner that is likely to produce efficiencies, the Commission has consistently maintained that this type of conduct amounts to illegal price fixing.

We recognize that physicians can join together and negotiate fees in ways that do not harm competition. Health care providers (including physicians) and those who pay for their services (*i. e.*, payors) are increasingly developing new and innovative approaches to health care delivery in order to increase quality and contain costs. It is important not only to protect health care consumers from anticompetitive activity, but also to avoid interference with this procompetitive activity.

We therefore approach this case with full recognition that innovative approaches to health care should be encouraged. We also recognize the frustration of many physicians over their perceived lack of bargaining power in negotiations with large health care payors. The Commission has already provided extensive guidance on the ways to accommodate both of these concerns, consistent with the antitrust laws.[2]

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[2] The Commission, along with the Department of Justice, recently issued a report on competition policy and health care, which was based on 27 days of public hearings

This is the first physician network case in over 20 years where the Commission has the benefit of a full administrative trial and record. This case thus presents an opportunity not only to resolve a specific controversy but also to provide some guidance to the health care community on the appropriate boundary between pro-competitive and anti-competitive activities.

The Administrative Law Judge (ALJ) concluded that Respondent North Texas Specialty Physicians' (NTSP) activities constitute unlawful horizontal price fixing, and that Respondent's collective price setting was not ancillary to any procompetitive activity. After our own *de novo*

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covering a broad range of health care topics, all focused on ways to promote innovative, cost effective and high quality health care services. The Fed. Trade Comm'n and the U.S. Dep't of Justice, *Improving Health Care: A Dose of Competition* (July 2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf [hereinafter *Health Care Hearings and Report*]. In addition, Commission staff regularly issue advisory letters to physician IPAs seeking advice on proposals for financial and clinical integration. A good example is the Commission staff's advisory letter to MedSouth, Inc., where staff did not object to a clinical integration proposal by an IPA that involved joint setting of fees. Advisory Opinion Letter from Jeffrey W. Brennan, Esq., FTC, to John J. Miles, Esq., Ober, Kaler, Grimes and Shriver 4 (Feb. 19, 2002), http://www.ftc.gov/bc/adops/medsouth.htm [hereinafter *MedSouth*]. The Commission and the Department of Justice have also issued extensive guidelines for antitrust enforcement policy in health care. *See* U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care* (1996) *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,153 [hereinafter *Health Care Statements*]; *see also* Thomas B. Leary, *Special Challenges for Antitrust in Health Care*, 18 No. 2 A.B.A. SEC. ANTITRUST 23 (Spring 2004).

review of the facts, we agree with the ALJ's conclusions and affirm his decision.[3] We adopt the findings of fact of the Initial Decision to the extent those findings are not inconsistent with this opinion.

We find that the activities of Respondent, taken as a whole, amount to horizontal price fixing which is unrelated to any procompetitive efficiencies. Respondent's conduct could be characterized as *per se* unlawful under the antitrust laws, and thus subject to summary condemnation. For the reasons explained below, however, it is more appropriate to apply the "inherently suspect" analysis of our recent decision, *Polygram Holding, Inc.*,[4] as affirmed by the

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[3] This opinion uses the following abbreviations for citations:

ID - Initial Decision
IDF - Numbered Findings of Fact in the Initial Decision
CX - Complaint Counsel Exhibit
RX - Respondent Exhibit
Tr. - Transcript of Testimony before the Administrative Law Judge
IH - Transcript of Investigational Hearing
Dep. - Transcript of Deposition
O.A. - Transcript of Oral Argument on Appeal
CCAB - Complaint Counsel's Appeal Brief
RAB - Respondent's Appeal Brief
RR - Respondent's Reply Brief

References to investigational hearing or deposition transcripts included in the trial record as exhibits are made using the exhibit number with the witness' name and type of interview provided in parentheses: CX__ (Van Wagner Dep. at __).

[4] 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003), *available at* http://www.ftc.gov/os/2003/07/polygramgramopinion.pdf [hereinafter *Polygram*, or *Polygram Comm'n Op.*].

D.C. Circuit, *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005). But, we also emphasize that a *per se* analysis and an inherently suspect analysis are close neighbors, and that the determination of illegality here does not require an elaborate inquiry into effects in the market.

II. Background

A. Respondent's Activities

NTSP is an organization of independent physicians and physician groups that was formed, and is managed and operated by, physicians. Although its size has varied, NTSP had approximately 575 members in 2003 and 480 members at the time of trial in April 2004. IDF 32. As of 2003, NTSP was comprised of practitioners in 26 medical specialties as well as some primary care physicians. *Id.* These doctors are located principally in the Tarrant County, Texas area, which includes the city of Fort Worth. IDF 31. The participant physicians have distinct economic interests reflecting their separate clinical practices. IDF 35. Many members compete with one another. IDF 36.

NTSP's main functions are to negotiate and review contract proposals for member services that are submitted by payors, including insurance companies and health plans; to review payment issues; and to act as a lobbyist for its members' interests. IDF 39. NTSP negotiates both risk-sharing contracts (risk contracts)[5] and non-risk-sharing

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[5] Risk-sharing contracts are also known as capitation contracts.

contracts (non-risk contracts). IDF 46. The former typically reimburse doctors on a dollar amount per patient basis, whereas the latter provide "fee-for-service" payment. IDF 13-15. The challenged conduct in this case involves solely the negotiation of non-risk contracts, which are far more common for NTSP.[6] IDF 46, 48-50. NTSP's original focus was on risk contracting when it was founded in 1995. IDF 19, 46. The initial interest of payors in NTSP's risk contract declined, however, and by 2001 NTSP's Board decided to center its focus on how to benefit its members for fee-for-service contracts in addition to risk contracts. IDF 46-50; CX 83 at 3. NTSP's Board has acknowledged that risk contracting "is a small part of the business." CX 83 at 3; IDF 46-50. In fact, at the time of oral argument, NTSP had only one risk contract (albeit a substantial one). IDF 49. Only about half of NTSP's physicians participate in its one risk contract. IDF 51; Van Wagner Tr. 1830; Frech Tr. 1353-54.

NTSP's physicians enter into a Physician Participation Agreement (PPA) with NTSP that grants NTSP the right to receive all payor offers and imposes on the physicians a duty to forward payor offers to NTSP promptly. CX 0276; CX 275 at 24. The physicians agree that they will not individually pursue a payor offer unless and until they are notified by NTSP that it has permanently discontinued negotiations with the payor. CX 0311 at 10; CX 0276; CX 1178 (Hollander Dep. at 68).

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[6] NTSP has 20 non-risk contracts. IDF 50; CX 1196 (Van Wagner IH at 14). It does not receive revenues from these contracts; it does, however, receive revenues from its one risk contract. IDF 21.

Each NTSP member's PPA provides that NTSP must promptly forward (messenger) the fee reimbursement and other economic provisions of any non-risk offer to the member physicians. CX 275 at 24. If more than 50 percent of the members accept those provisions, NTSP will then proceed to negotiate the contract. IDF 67; CX 275 at 25-26. At times NTSP has gathered powers of attorney from its physicians, which give NTSP the legal authority to negotiate non-risk contracts on behalf of those physicians. CX 1173 (Deas IH at 56-57); Palmisano Tr. 1250-51.

NTSP conducts annual polls of its physicians to determine minimum reimbursement rates for use in negotiation of health maintenance organization (HMO) and preferred provider organization (PPO) product contracts with payors. CX 1195 (Van Wagner Dep. at 66-67). NTSP's polling form asks physicians individually for the minimum payments that they would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. CX 0565; CX 1196 (Van Wagner 111 at 26-29, 43-44, 62). NTSP uses the poll responses to calculate the mean, median, and mode (averages) of the minimum acceptable fees identified by its physicians, and then uses these measures to establish its minimum contract prices. IDF 93. NTSP then reports these measures back to its participating physicians. CX 0103 at 4-5; CX 1196 (Van Wagner IH at 26-29, 43-44, 62); CX 1042. NTSP's polling form explains to the participating physicians that "NTSP polls its affiliates and membership to establish Contracted Minimums NTSP then utilizes these minimums when

negotiating managed care contracts on behalf of its participants." CX 0387 at 1; CX 0633.

B. History of the Case and Summary of Initial Decision

The Commission's complaint, issued on September 16, 2003, charges NTSP with the unlawful negotiation of agreements among its physicians on price and other terms, refusal to deal with payors except on collectively agreed-upon terms, and refusal to submit payor offers to its physicians unless the terms complied with NTSP's minimum-fee standards. Administrative Law Judge D. Michael Chappell filed an Initial Decision upholding the complaint on November 8, 2004.

In the Initial Decision the ALJ found that NTSP is controlled by its participant physicians and had taken collective action to establish and extract fee concessions from payors. ID at 52-56, 64-66, 70-83. The ALJ rejected the claim that NTSP was a single entity incapable of conspiring with its members. *Id.* at 70-71. He concluded that NTSP's conduct amounted to "a horizontal price fixing agreement." *Id.* at 86. He recognized that courts have applied *per se* analysis to horizontal price fixing, and made a number of specific findings that would support this characterization. IDF 364-80. However, he did not ultimately conclude that NTSP's conduct was *per se* unlawful. Instead, he followed the Supreme Court's analysis in *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999), and distinguished NTSP's conduct from the conduct of the dentists' group in that case. ID at 85-88.

The ALJ found that the PPA gives NTSP the exclusive right initially to negotiate with payors and requires physicians to submit to NTSP offers that they may individually receive. IDF 65. Physicians may negotiate individually only after NTSP discontinues its efforts. IDF 66. The ALJ also found that NTSP reinforces this negotiation exclusivity by powers of attorney or agency authorizations it receives from its members, and that it urges its members to tell payors to communicate their offers directly to NTSP. IDF 70, 76-82.

The ALJ found that, despite the requirements in the PPA, NTSP actually messengers to its members only those non-risk contract proposals in which reimbursement fees exceed NTSP's minimum reimbursement schedule developed from the annual poll of members. IDF 68, 85, 87. This rate is expressed as some percentage of Medicare's Resource Based Relative Value System, a fee schedule used to set the reimbursement amounts Medicare will pay for thousands of different services. IDF 10-12, 89-90. Although doctors do not consult with each other about their responses to the poll, NTSP computes the responses and informs its members of the averages. IDF 92-94. The ALJ found that this information enables members to assess the benefits of collective contracts though NTSP and reduces their uncertainty about other members' price-setting intentions. IDF 99-100.

The Initial Decision described NTSP's negotiations with three health plans – United, Cigna and Aetna, in which NTSP exercised its negotiating authority through its PPA and/or agency agreements or powers of attorney, and utilized its minimum

reimbursement schedule. B3 at 74-82. In several instances in these negotiations NTSP terminated, or threatened to terminate, its contract with a health plan. *Id.*

The ALJ rejected Respondent's claim that it was a single entity incapable of conspiring with its members, ID at 70-71, and held that evidence of direct agreements among physicians was not needed to demonstrate the conspiracy. *Id.* at 68-69. The ALJ relied on *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 356 (1982), where the Court found concerted action without finding that the competing physicians agreed directly with each other to set prices. The ALJ also found that NTSP had offered no plausible claim that its collective price setting was ancillary to any procompetitive activity. ID at 87. He therefore concluded that "the actions taken by NTSP to coerce health insurance payors to increase their offers of rate reimbursement or to offer more favorable economic terms to NTSP's physicians constitute an unreasonable restraint of trade." ID at 88. He also found that NTSP's actions had caused payors to increase their offers, and concluded that this fact provided sufficient evidence of anticompetitive effects, to the extent an examination of effects is required. *Id.* at 87. The ALJ issued an order that requires NTSP to cease and desist from collective price fixing in its negotiation of non-risk contracts and to terminate any existing non-risk contracts. *Id.* at 92-97.

C. Questions Raised by the Appeal

1. Respondent's Appeal

Respondent appeals from the ALJ's determination that its conduct violated Section 5 of the FTC Act, and also maintains that the ALJ's cease and desist order is not appropriate. Respondent's supporting arguments sometimes overlap, but may be sorted out as follows:

First, Respondent argues that the Commission lacks jurisdiction over NTSP because it is a memberless non-profit organization, which is not engaged in interstate commerce.

Second, Respondent argues that the ALJ erred in finding that Complaint Counsel had shown concerted action when there was no evidence of direct collusion among NTSP's physicians. Respondent asserts that NTSP cannot and does not bind any participating physicians to its non-risk contracts, and that any non-risk contracts to which NTSP decides to become a party must be messengered to the physicians for their individual decisions on whether to join.

Third, Respondent contends that even if Complaint Counsel had shown there was concerted action, the conduct must be analyzed under the rule of reason. Respondent argues that the ALJ therefore erred when he found a violation, because Complaint Counsel did not meet their burden to show anticompetitive effects in a properly defined relevant market.

Fourth, Respondent argues that the ALJ erred when he found that NTSP had insufficient evidence of procompetitive justifications. Respondent asserts that all the evidence available shows that NTSP had legal and business justifications for its actions. Respondent argues that the ALJ compounded this error when he denied NTSP discovery needed to further establish its procompetitive justifications.

Fifth, Respondent argues that it was error for the ALJ to find that NTSP's conduct had a net anticompetitive effect in the absence of any showing by Complaint Counsel that there was a less restrictive alternative or that NTSP's justifications for its conduct were pretextual.

Sixth, Respondent argues that it was error for the ALJ to enter an order that was not narrowly tailored to any antitrust violation properly found.

2. Complaint Counsel's Appeal

Complaint Counsel appeal two aspects of the ALJ's decision, but otherwise ask that the Commission affirm the finding of liability. First, Complaint Counsel argue that it was error for the ALJ to hold it was necessary to prove a relevant market in the case of a *per se* unlawful price-fixing agreement. Complaint Counsel argue that no proof of market definition or market power is required to establish a *per se* violation, and that any naked price agreement among competitors (actual or potential) is conclusively presumed unlawful.

Second, Complaint Counsel argue that the ALJ's order is too narrow and fails to provide essential relief. Complaint Counsel argue that the

core prohibitions fail to provide adequate protection against further violation. Complaint Counsel also argue that the ALJ added two unwarranted provisos that are likely to enable NTSP to continue certain conduct that the ALJ found was used to accomplish the unlawful price-fixing scheme.

III. Jurisdictional Issues

We consider this issue first, although Respondent does not give it prominence. The Commission has jurisdiction over NTSP as a corporation only if NTSP is organized to carry on business for the pecuniary benefit of its members and NTSP's conduct at issue is "in or affecting commerce." 15 U.S.C. §§ 44, 45 (1994). Respondent contends that it was error for the ALJ to find that the FTC has jurisdiction over NTSP because NTSP is incorporated under Texas law as a "memberless" non-profit organization (and therefore its physicians are not "members" of NTSP), and none of NTSP's actions were in interstate commerce. RAB at 58-59.

We find that NTSP clearly is a "corporation" within the meaning of Section 4 of the FTC Act because NTSP is "organized to carry on business for its own profit or that of its members." 15 U.S.C. § 44. In the words of NTSP official Dr. John Johnson, "NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups to hopefully be able to secure contracts, improve patient care, and provide a voice at the table for physicians. . . . [It was] to represent physicians . . . in obtaining contracts from businesses or insurance companies or in dealing with hospitals." CX 1182 (Johnson Dep. at

10-11).[7] NTSP's primary function – marketing its physicians to payors – satisfies the pecuniary benefit test of FTC jurisdiction. Indeed, we find that NTSP does not appear to have any purpose other than to carry on business for the profit of its members. It is not necessary for the challenged conduct to increase NTSP's members' profits, as NTSP intimates. In *California Dental*, 526 U.S. at 767 n.6, the Supreme Court stated, "[i]t should go without saying that the FTC Act does not require for Commission jurisdiction that members of an entity turn a profit on their membership, but only that the entity be organized to carry on business for members' profit."

NTSP's argument that its physicians are not "members" because of the way it is incorporated elevates form over substance.[8] NTSP's physicians possess sufficient indicia of membership to qualify as members within the meaning of Section 4:

- They come together with other members of their profession to promote their common business interests.
- They elect representatives to its governing board.

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[7] *See also* CX 350 ("NTSP was started in an attempt to provide a seat at the table of medical business for the individual specialty physicians . . . . NTSP through, [sic] PPO and risk contracts, has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source."); CX 550.

[8] The mere form of incorporation is not controlling in matters of FTC jurisdiction. *See Cmty. Blood Bank of the Kansas City Area, Inc. v. FTC*, 405 F.2d 1011, 1018-19 (8th Cir. 1969).

- They contribute funds to finance NTSP's activities.
- NTSP internal documents refer to its physicians as "members."

IDF 20, 21, 24, 33, 42, 44, 48, 160, 282, 326.

We further find that NTSP satisfies the interstate commerce jurisdictional requirement because NTSP's actions to maintain physician fee levels, if successful, could be expected to affect the flow of interstate payments from out-of-state payors to NTSP physicians. There is no need to prove actual effects on interstate commerce, or to quantify the effect. The Supreme Court on numerous occasions has emphasized the breadth of federal antitrust jurisdiction, even when wholly intrastate conduct of local actors is challenged.[9]

IV. Legal Framework

In order to find liability under Section 5 of the FTC Act, we will examine first, whether there was an "agreement" between independent actors and, second, whether this agreement unreasonably restrained trade.[10] Our overall evaluation of NTSP's

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[9] *See, e.g., Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 328-31 (1991); *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 241 (1980); *Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 743-45 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 784-85 (1975).

[10] For purposes of this case, we can assume that the definition of "unfair methods of competition" under the FTC Act, 15 U.S.C. § 45, is the same as the definition of a "contract combination . . . or conspiracy, in restraint of trade . . . ." under Section 1 of the Sherman Act, 15 U.S.C. § 1.

conduct is guided by a rich jurisprudence that extends over almost 100 years,[11] and particularly by the very recent decision of the Supreme Court in *California Dental* – a case that was in turn followed by the Commission in its own opinion in the *Polygram* case and by the D.C. Circuit Court's affirming opinion, *Polygram Holding*, 416 F.3d 29. We will occasionally refer to the Department of Justice and FTC Health Care Statements, but it should be understood that we do not consider the *Health Care Statements* as substantive authority in their own right but rather as concise summaries of what we believe the law to be. We are also informed by our own enforcement experience with combinations similar to NTSP and by the Commission's *Health Care Hearings and Report*. In this section we will explain why we have chosen to apply the flexible tools of *Polygram* rather than a simple *per se* analysis in this case, and we will then describe *Polygram's* methodology in more detail.

A. Choice of Standard

The Commission's unanimous *Polygram* opinion was its first attempt to respond to the approach of the Supreme Court's *California Dental* decision. These opinions describe how the analysis of horizontal restraints has evolved over the last 100 years, and establish a flexible methodology for courts to determine whether a challenged restraint is illegal. They go beyond the simple dichotomy

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[11] The requirement that the restraint be unreasonable – coupled with recognition that some restraints can conclusively be presumed so – dates from 1911 in *Standard Oil Co. v. United States*, 221 U.S. 1, 58 (1911).

between categories like "*per se*" or "rule of reason," and establish a continuum within which behavior can be analyzed.

At one polar extreme, there still is a category of offenses that are considered *per se* illegal, for which liability depends solely on whether defendants did or did not do certain things. These offenses include, most prominently, so-called "naked" price fixing or market allocation agreements. Longstanding precedent holds that the courts will not entertain any arguments that these restraints will yield beneficial, or even benign, results. Parties cannot defend, for example, on the ground that prices have been set at "reasonable" levels[12] or that coordination is necessary for survival in times of distress.[13] We do not believe that the *per se* condemnation of naked restraints has been affected by anything said either in *California Dental* or *Polygram*.

There is precedent for outright *per se* condemnation of conduct that parallels the conduct in issue here. The Supreme Court held in *Maricopa*, 457 U.S. at 356-57, that traditional antitrust laws apply to price fixing in the context of physician fee negotiation, and held that it was *per se* unlawful horizontal price fixing for a group of competing physicians to agree to set a maximum fee to offer health insurers for providing medical services to

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[12] *See United States v. Trenton Potteries Co.*, 273 U.S. 392, 398-99 (1927); *United States v. Addyston Pipe Steel Co.*, 85 F. 271, 288-91 (6th Cir. 1898), *aff'd* 175 U.S. 211 (1899).

[13] *See United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218-21, 229 (1940).

patients. The means used to implement a price fixing agreement in *Maricopa* are similar to those used by NTSP. In *Maricopa*, the medical societies: (a) set a maximum price for health services that could be charged to policyholders of approved health insurance plans,[14] (b) used polling as a device for determining the price; (c) did not necessarily have agreement directly between physicians in the price-setting process; and (d) allowed the physicians the freedom to set their own prices.[15]

We also are familiar with these practices and this industry.[16] The Commission has issued complaints in numerous cases, which challenge conduct by physician IPAs similar to that in *Maricopa* and that in the case at hand. *See, e.g.*, *supra* note 1. The FTC and Department of Justice *Health Care Statements* provide specific warning

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[14] Note that in one respect the conduct here is even worse than that condemned in *Maricopa* because NTSP has set minimum prices. *See* Section V.B. 1.a.

[15] *Arizona v. Maricopa County Med. Soc'y*, 1979 WL 1638 at *1 (D. Az. June 5, 1979), *aff'd*, 643 F.2d 553 (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982).

[16] A *per se* characterization would not necessarily be foreclosed, even if we did not have this industry-specific experience. *Maricopa* stated that the *per se* rule does not need to "be rejustified for every industry that has not been subject to significant antitrust litigation." 457 U.S. at 350-51. On the other hand, *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 9 (1979), emphasized that a *per se* label is appropriate only when courts "have had considerable experience with certain business relationships." We do not need to parse these statements closely, in light of our experience with both the industry and the practices.

about the illegality of this type of conduct. *See Health Care Statements, supra* note 2, *Statement* 8.

Although NTSP's activities could be characterized as *per se* illegal because they are closely analogous to conduct condemned *per se* in this and other industries, we will not apply that label here and now in this particular case. There are two reasons.

First, in the years since *Maricopa* was decided, the Supreme Court has urged caution in the application of the *per se* label to conduct in a professional setting where "the economic impact . . . is not immediately obvious." *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 459 (1986); *see also California Dental*, 526 U.S. at 770-71. Some migilit claim that the likely economic impact of the restraints in issue here is "immediately obvious" enough to satisfy this standard, but we do not need to reach that question because we have available in this case an extensive record on which to buttress our conclusions about the likely effects of Respondent's conduct.

Second, since *Maricopa*, we have a better understanding of the potential integration efficiencies of physician IPAs. We would view NTSP's activities very differently if NTSP were able to demonstrate that the participating physicians were financially or clinically integrated in performing its numerous non-risk contracts, and thus driven by incentives similar to those present in its single remaining risk contract. Under the well-established law of ancillary restraints, recent precedents like *Polygram*, and the principles described in our *Health Care Statements* and

Competitor Collaboration Guidelines,[17] Respondent could have prevailed if the integrated venture were likely to enhance efficiencies and NTSP's conduct were reasonably related to the overall agreement and reasonably necessary for achieving those efficiencies. *See* discussion in Section V.C.1., *infra*. This means that some initial inquiries about whether there is integration, the likely effects of integration, and the reasonableness of the specific restraint are necessary in order to decide whether to apply a rule of reason. It is of course possible to conclude we then have a *per se* case based on a *per se* illegal restraint if these initial inquiries are decided adversely to a respondent. But, it is semantically awkward to use a *per se* label once a number of "reasonableness" issues have been addressed, sometimes at length. What does it really mean to say we have a *per se* case, once we have considered and rejected justifications for a restraint? What it means, as a practical matter, is that no further proof of market effects is required; the case is over. As will be made clear in the discussion below, however, we arrive at exactly the same result when we follow the "inherently suspect" analysis outlined in *Polygram* – and the *Polygram* framework more accurately describes the actual analysis of the case.

These considerations might not deter us when we are persuaded by experience and economic logic that the potential for harm is overwhelming and the possible justifications are attenuated and uniformly

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[17] Fed. Trade Comm'n and U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors* (2000), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,161 [hereinafter *Competitor Collaboration Guidelines*].

rejected by courts. We would simply apply the *per se* label. In the health care sector, however, the Commission wants to encourage providers to engage in efficiency-enhancing collaborative activity.[18] We do not want to chill consideration of this activity by use of terminology that could be misunderstood. This is not a factor that was considered in *Maricopa* over twenty years ago, but we do think it is a factor that needs to be considered after a decision like *California Dental*.

So, at least this time, after the first full administrative trial in a generation, we will instead follow the methodology of *Polygram*, and consider each of Respondent's justifications in some detail. We want to emphasize again, however, that this is not the same thing as a full blown rule of reason inquiry. If we find that Respondent's proffered justifications for NTSP's inherently suspect conduct are not legitimate – after the examination that follows – it is not necessary to go on and find actual adverse market effects. *See* Section V.E. *infra*.

The *Polygram* Analysis

In the words of the D.C. Circuit, an offense can be described as "inherently suspect" when there

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[18] *See generally MedSouth*, *supra* note 2, where Commission staff did not recommend the Commission take enforcement action against a physician IPA proposal whereby the IPA physicians would collaborate on information sharing, treatment coordination, practice protocols, and enforcement standards. *See also* Thomas B. Leary, *The Antitrust Implications of "Clinical Integration": An Analysis of FTC Staff's Advisory Opinion to MedSouth*, 47 ST. LOUIS U. L. J. 223 (Spring 2003).

is a "close family resemblance between the suspect practice and another practice that already stands convicted in the court of consumer welfare." *Polygram*, 416 F.3d at 37. The determination is based on the conduct's "likely tendency to suppress competition." *Polygram Comm'n Op. supra* note 4, at 29. As the Commission described, "[s]uch conduct ordinarily encompasses behavior that past judicial experience and current economic learning have shown to warrant summary condemnation." *Id.* At this stage, the focus of the inquiry is on the nature on the restraint rather than on the market effects in a particular case.[19] If a plaintiff is able to make an initial showing that particular conduct meets these strictures, and the defendant makes no effort to advance any procompetitive justification for the conduct, then the case is concluded and the practices are condemned. *Polygram Comm'n Op. supra* note 4, at 29.

A defendant can avoid summary condemnation, however, if it can advance a legitimate justification for the practice. As we explained in *Polygram*, "[s]uch justifications may consist of plausible reasons why practices that are competitively suspect as a general matter may not be expected to have adverse consequences in the

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[19] As the D.C. Circuit pointed out in *Polygram*, this is not a fixed category. It must evolve "as economic learning and market experience evolve." 416 F.3d at 37; *see also* Thomas B. Leary, *A Structured Outline for the Analysis of Horizontal Agreements*, http://www.ftc.gov/speeches/leary/chairsshowease.talk.pdf at 7-10, (describing distinction between cases "that focus on the nature of the restraint" and those "that focus on the nature of the market") (emphasis in original).

context of the particular market in question; or they may consist of reasons why the practices are likely to have beneficial effects for consumers." *Id.* The defendant need only articulate a legitimate justification, and is not obliged to prove the competitive benefits. (Remember that the issue at this initial stage is simply whether the practice should be condemned summarily.) The proffered justifications, however, must be both cognizable under the antitrust laws and at least facially plausible. *Id.* at 30-33. The cognizable justification requirement allows a tribunal to reject as a matter of law proffered justifications that are incompatible with the goal of antitrust law to protect competition. We described cognizable justifications in our *Polygram* opinion, *id.* at 31:

> Cognizable justifications ordinarily explain how specific restrictions enable the defendants to increase output or improve product quality, service, or innovation. By contrast, courts since the earliest decades of the Sherman Act have identified classes of justifications that, because they contradict the procompetition aims of the antitrust laws will not save restraints from condemnation. For example, a defendant cannot defend restraints of trade on the ground that the prices the conspirators set were reasonable, that competition itself is unreasonable or leads to socially undesirable results, or that price increases resulting from a trade restraint would attract new entry.

The D.C. Circuit expressly approved the requirement that a proposed justification be both cognizable and plausible. Even though the justification offered by *Polygram* seemed plausible "[a]t first glance," the court rejected it as "nothing less than a frontal assault on the basic policy of the Sherman Act." *Polygram*, 416 U.S. at 37-38 (quoting *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. 679, 695 (1978)).

If the justification for a suspect restraint is cognizable – which is to say, admissible in the first place – a defendant must also show that it would plausibly create or improve competition. Again, to quote *Polygram*:

> A justification is plausible if it cannot be rejected without extensive factual inquiry. The defendant, however, must do more than merely assert that its purported justification benefits consumers. Although the defendant need not produce detailed evidence at this stage, it must articulate the specific link between the challenged restraint and the purported justification to merit a more searching inquiry into whether the restraint may advance procompetitive goals, even though it facially appears of the type likely to suppress competition.

Id. at 31-32.[20]

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[20] The concept of ancillary restraints, which allows an agreement that would otherwise be viewed as a

If a defendant is able to advance a justification that meets both of these requirements – cognizable and plausible – the plaintiff must then make a more detailed showing that the restraints at issue are likely to harm competition. *Id.* at 32. The degree of proof required depends on the circumstances of the case and the degree to which antitrust tribunals have experience with the restraint in question. *Id.* The Supreme Court stated succinctly that the inquiry must be "meet for the case." *California Dental*, 526 U.S. at 781. In *Polygram*, the Circuit Court used similar language, stating that, "the extent of the inquiry is tailored to the suspect conduct in each particular case," 416 F.3d at 34. We interpret this precedent as endorsement of a "spectrum" or "sliding scale" analysis, which more accurately describes the way cases are actually decided today.[21]

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naked restraint of trade to be evaluated in light of the procompetitive effects of an efficiency-enhancing integration of economic activity to which it is reasonably related, is subsumed in the Commission's *Polygram* analysis. *See Polygram Comm'n Op., supra* note 4, at n.42 ("[t]he ancillary restraints doctrine retains its vitality in evaluating efficiency claims. . . . [w]hether or not expressed in terms of ancillarity, the link between defendant's "plausible" justification and a cognizable benefit must be clear."). As will become clear after the discussion of specific facts, NTSP's conduct is not justified under either a pre-*Polygram* ancillarity analysis, or *Polygram's* more inclusive analysis.

[21] We believe that this analytical framework may also help to resolve the apparent inconsistency between those decisions that use *per se* terminology and those that use rule of reason terminology in facially similar situations. *See* cases cited in ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS, 53-58 (5th ed. 2002).

B. The Health Care Statements

The FTC and Department of Justice *Health Care Statements* provide guidance about the agencies' enforcement intentions on issues which are likely to arise in the health care industry. They lay out principles that we believed to be consistent with the state of the law when they were issued in 1993 and revised in 1994 and 1996. Even though the *Health Care Statements* were issued before the *California Dental* or *Polygram* opinions were written, and also before the Competitor Collaboration Guidelines were issued, we believe that their analysis of horizontal restraints among competing physicians is still viable and also uniquely valuable because of their specificity. The *Health Care Statements* lay out the circumstances when a rule of reason analysis is appropriate for price-setting conduct between competing physicians and – like the analysis in *Polygram* – they allow for procompetitive justifications in certain circumstances. *See Health Care Statements, supra* note 2, *Statement* 8.

Price-setting conduct of physician networks qualifies for rule of reason treatment where the "physician's integration through a network is likely to produce significant efficiencies" and the agreement on price is "reasonably necessary to realize those efficiencies." *Health Care Statements, supra* note 2, *Statement* 8B1.[22] The *Health Care Statements* describe two different types of

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[22] The *Competitor Collaboration Guidelines, supra* note 17, refer to "cognizable efficiencies" for which the restraint in issue is "reasonably necessary." §§ 3.36(a), 3.36(b).

integration that can qualify a physician network for rule of reason treatment – financial and clinical. *Id.* The Commission has applied this analysis in numerous enforcement actions.

Although our analysis of NTSP's conduct generally follows the legal framework outlined in *Polygram*, we also refer to the industry specific concepts identified in the *Health Care Statements* to the extent appropriate.

V. Analysis of the Challenged Restraints

A. Existence of an Agreement

In order to decide whether there is a violation of Section 5 of the FTC Act in this case, we will first look to see if there is an agreement. There is a fundamental distinction between unilateral and multilateral action. The matter is easy to decide when two or more separate legal entities overtly agree on a restraint that each will adopt. However, an action nominally taken by a single entity is also construed as the product of agreement for purposes of the antitrust laws when the entity is controlled by a group of competitors and is serving as the agent of the group. There are many ways that association/agents can legally act for the collective benefit of the group. Associations can, for example, negotiate prices for office facilities or wages for employees; agents can establish prices for services that the association itself provides for members or non-members. These are matters of no antitrust significance, because there is no conceivable anticompetitive impact. However, if the association negotiates prices for services that the *members* will provide, the organization's conduct is considered to

be that of a combination or conspiracy of its members, not unilateral action.[23]

The Commission has also held that when an organization is controlled by a group of competitors, the organization is viewed as a combination of its members, and their concerted actions will violate the antitrust laws if an unreasonable restraint of trade. *In the Matter of Michigan State Med. Soc'y*, 101 F.T.C. 191, 286 (1983). The Commission's long list of consent agreements in this industry are all based on this uncontroversial legal premise. *See, e.g., supra* note 1.

The basis for this jurisprudence is sound. Without it, any group of competitors could avoid antitrust liability for collective price fixing simply by acting through single organizations that they control (as many have attempted).[24] Thus, in order to determine if there is an agreement in this case, we must first determine whether NTSP is controlled by competing physicians.

Respondent states that NTSP is a 5.01(a) memberless non-profit corporation under Texas

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[23] *See, e.g., Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 694-96; *United States v. Sealy, Inc.*, 388 U.S. 350, 352-54 (1967). *Cf. Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 509 (1988); *Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of the Univ. of Oklahoma*, 468 U.S. 85, 99 n.18 (1984).

[24] *See supra* note 23. They could, for example, coordinate their activities through a single "trust." It would seem rather odd to immunize this kind of activity, given the popular name of the basic legal regime we apply here: "The Antitrust Laws."

law.[25] RAB at 14. Respondent argues that because of this "memberless" status, NTSP should be viewed as a sole actor, both in management of its affairs, and in its refusal to deal with payors on non-risk contracts, and that therefore NTSP cannot be found to conspire under Federal competition law. *Id.* at 14-15. At the outset, we reject this argument. Substance prevails over form in antitrust law, and the technical manner in which an organization is incorporated does not control.[26] We have to look beneath the surface.

We find that NTSP is controlled by competing physicians, and therefore is not a sole actor for purposes of the antitrust laws. We agree with the ALJ's conclusion that NTSP's participating physicians have taken collective action to obtain higher fees from payors. ID at 53-55. The fact that NTSP physicians elect representatives from their ranks to serve on the eight- member Board of Directors of NTSP and set NTSP policy supports this conclusion. IDF 23, 24, 33, 38.

Respondent's briefs rely heavily on *Viazis v. American Ass'n of Orthodontists*, 314 F.3d 758 (5th Cir. 2002), to assert that NTSP's mere existence does

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[25] Section 5.01(a) of the Texas Medical Practice Act allows non-profit entities to engage in the practice of medicine for the purposes of research, medical education, or the delivery of health care to the public. TEX. OCC. CODE. ANN. § 162.001 (Vernon 2004).

[26] In *Community Blood Bank*, 405 F.2d at 1018-19, the circuit court determined that jurisdiction was to be determined "on an ad hoc basis" and that the mere form of incorporation was not controlling.

not satisfy the concerted action requirement of Sherman Act Section 1. RAB at 12. Respondent's discussion of *Viazis* has confused the requirement of "collective action" with the separate requirement of an "unreasonable restraint of trade." *Viazis* merely states that a trade association is not by its nature a "walking conspiracy" even though it inherently involves collective action by competitors – there must also be an unreasonable restraint of trade. *Viazis*, 314 F.3d at 764. We do not disagree.

Respondent also argues that because NTSP cannot and does not bind any of its physicians to non-risk contracts, there cannot be any collusion among physicians (and therefore no agreement). RAB at 8. Respondent cites ALJ findings that the doctors did not discuss among themselves or directly enter into price agreements with one another, and points out that the ALJ's fording that there was no collusion among NTSP's physicians was based on this evidence. RAB at 11. This argument, as presented, conflates what really are two separate issues.

The first issue raised by this particular argument is whether parties can enter into an agreement absent direct communication with each other. It has long been settled that they can. In *Maricopa*, the Supreme Court found an agreement among physicians without finding that the competing physicians agreed directly with each other. 457 U.S. at 356; *see also* ID at 68.

Similarly, in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia* 624 F.2d 476, 479-81 (4th Cir. 1980), the court found collective action by a group that was controlled by its

physician members without finding that the plan's individual physicians had met and agreed directly with each other. The *Health Care Statements* also explain that physicians do not have to directly agree with one another to engage in price fixing, and that a common agent can be used to exert the bargaining leverage of a group of physicians *Health Care Statements, supra* note 2, Statement 9D1 and 9D4 n.66. In this case, it is enough that participating physicians individually authorized NTSP to take certain actions on their behalf, knowing that others were doing the same thing.[27] Indirect communications of this kind are sometimes referred to as "hub-and-spoke" conspiracies.[28]

The second issue is whether it is possible to find that there was an agreement on price even though individual physicians were not bound to adhere to contract terms negotiated by NTSP. We address this issue in the discussion of NTSP's restraints in Section V.B.1. immediately below (analysis of whether NTSP's conduct amounts to

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[27] For example, NTSP would inform physicians who had not yet granted it contract negotiation authority but were considering it, the number of other member physicians who had already given NTSP that authority. CX 1066 at 1; CX 0548 at 1.

[28] *See, e.g., Toys "R" Us, Inc. v. FTC*, 221 F. 3d 928, 934-36 (7th Cir. 2000) (finding evidence of horizontal agreement where petitioner served as "ringmaster"); *United States v. Masonite Corp.*, 316 U.S. 265, 276 (1972) (fixing of prices by one member of group pursuant to express delegation, acquiescence, or understanding just as illegal as fixing of prices by direct, joint action); *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 227 (1939) ("unlawful conspiracy may be and often is formed without simultaneous action or agreement").

price fixing). It is enough to say here that the opt-out right does not negate the existence of an agreement.

Restraint of Trade – *Prima Facie Case*

We next examine whether NTSP's conduct amounts to a restraint of trade, specifically, price fixing. First we look at the factual evidence to determine whether the conduct amounts to price fixing, and is thus illegal absent a cognizable and plausible justification. We discuss different kinds of activity separately for convenience and to provide guidance about what we regard as highly suspect behavior. We want to make clear, however, that our ultimate conclusions in this case do not stand or fall on our assessment of separate actions; the ultimate conclusions are rather predicated on the likely effects of the actions taken together.[29]

After discussion of the restraints separately, we then address in Section V.C. below the justifications advanced for each of them. We also describe the conduct that the Commission does not find to be price fixing in Section V.D., in order to give guidance to the health care community.

1. Challenged Restraints

a. NTSP's Use of a Poll

NTSP conducts annual polls of its physicians to determine minimum reimbursement rates for use in negotiation of HMO and PPO product contracts

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[29] The decision to view the conduct as a whole in this case should not be understood to mean that any one of the actions is necessarily benign standing alone.

with payors. CX 1195 (Van Wagner Dep. at 66-67). NTSP's polling form asks the physicians individually for the minimum price that they would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. CX 0565; CX 1196 (Van Wagner IH at 26-29, 43-44, 62). NTSP uses these poll responses to calculate the mean, median, and mode of the minimum acceptable fees identified by its physicians, and then uses these averages to establish its minimum contract prices. NTSP then reports these measures back to its participating physicians. CX 0103 at 4-5; CX 1196 (Van Wagner IH at 26-29, 43-44, 62); CX 1042. NTSP's polling form explains to the participating physicians that "NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants." CX 0387 at 1; CX 0633.

We find that NTSP's use of a poll facilitated a price-fixing agreement among its competing physician members. Frech Tr. 1316-24; 1326. NTSP physicians were aware that NTSP would use individual member's poll responses to create group "averages" that would be used by their organization in the coming year's negotiations with payors. IDF 88-90, 93-94. It was a way to communicate to their competitors what they would <u>like</u> to get in the future – not what they had gotten in the past, or, indeed, what they might settle for individually. When they cast a vote on the desired minimum price for the group, they were not simply reporting past or current prices, they were telegraphing their intentions about future prices. Thus, NTSP physicians anticipated that any individual response

would help to raise or lower the average fee for the group – an average that NTSP would then use in negotiating with payors. *See* IDF 88, 96100. NTSP physician responses to the polls were *interdependent* and not independent.

Respondent argues that NTSP's use of its poll and its minimum reimbursement schedule are not concerted action and have legitimate business purposes.[30] RAB at 21-22. Respondent states that NTSP does not divulge to any physician or board member whether or how any other individual physician responds to the confidential poll conducted by NTSP's staff. *Id.* at 23-24. Respondent also claims that NTSP does not use the averages derived from the polls to negotiate for higher rates, and NTSP's actions related the establishment and use of the threshold rate are purely internal to NTSP. *Id.* at 21-22. Even if NTSP's becomes a party to the contract, Respondent states that each physician still has an individual right to decide whether to become a party; physicians are not bound to their poll responses, and the poll does not require or induce a physician to contract in a particular manner or even at all. *Id.* at 22. Respondent points out that less than 34 percent of the physicians responded to the poll. *Id.* at 23. Furthermore, Respondent states that when NTSP's board makes a decision on a payor's offer, it is not binding on the physicians. *Id.* at 22-23.

Respondent further argues that Complaint Counsel's expert (Dr. Frech) was unable to find any evidence of collusion among physicians, and

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[30] We address Respondent's efficiency arguments associated with NTSP's poll in Section V.C. below.

admitted that physicians chose not to contract through NTSP on more than two-thirds of the contract offers NTSP messengered. RAB at 8-10. According to Respondent, Dr. Frech also determined that physicians frequently enter individually into payor contracts at rates both above and below the threshold rate levels. RAB at 10-11, 23.

Respondent's argument that NTSP does not divulge to any physician or board member whether or how any particular physician responds to the poll is of no consequence because liability in this case is not predicated on individual discussions among physicians themselves. It is predicated on an improper delegation of individual pricing authority to a common agent. The fact that NTSP's decisions on payor offers were not binding, and often ignored, does not absolve NTSP from liability because the law is clear that agreements can be illegal even though all the price terms are not specified or adhered to. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 647-48 (1980); *Socony-Vacuum Oil*, 310 U.S. at 218-24; and *Plymouth Dealers' Ass'n of Northern California v. United States*, 279 F.2d 128, 130-33 (9th Cir. 1960), all stand for the proposition that price fixing encompasses a broad range of actions that affect, but do not necessarily determine, the final price. *Socony-Vacuum Oil*, 310 U.S. at 223, made clear that "a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity" is price fixing. In *High Fructose Corn Syrup Antitrust Litigation*, 295 F.3d 651, 656 (7th Cir. 2002), Judge Posner stated that "[a]n agreement to fix list prices is . . . a per se violation of the Sherman Act, even if most or for that matter all

transactions occur at lower prices." Judge Posner explained that "the list price is usually the starting point for the bargaining and the higher it is (within reason) the higher the ultimately bargained price is likely to be." *Id.* Even if there is variability, NTSP's use of a minimum schedule (obtained from polling results) affects the level at which variability occurs. NTSP's conduct thus has the same effect on price as the conduct identified in *Plymouth Dealers* and *High Fructose Corn Syrup.*

Complaint Counsel's expert, Professor Frech, explained that NTSP's minimum-fee schedule coupled with its right of first negotiation (via the PPA) hinders payors' ability to contract directly with physicians. Frech Tr. at 1315-17; 1326-27. This was confirmed by payor testimony. *See, e.g.*, Quirk Tr. at 316-17. Professor Frech also explained that the NTSP minimum reimbursement rates were higher than what some physicians were actually willing to accept, and that negotiation of a minimum price offer has the effect of raising the prices that "low end" physicians would otherwise earn, without reducing the price that "high end" physicians would receive (they can opt out). Frech Tr. 1321-24. Thus, the minimum NTSP price schedule does have a tendency to increase prices overall, and can be characterized as horizontal price fixing.[31]

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[31] *See Nat'l Elec. Contractors Ass'n, Inc. v. Nat'l Constructors Ass'n*, 678 F.2d 492, 500 (4th Cir. 1982) (*citing Yarn Processing Patent Validity Litig.*, 541 F.2d 1127, 1137 (5th Cir. 1977), *cert. denied*, 435 U.S. 910 (1977) (interference with the market forces freely setting prices sufficient to constitute price fixing)).

The fact that only 34 percent of NTSP physicians responded to the polls does not alter this conclusion. A low response rate could, of course, further reduce the utility of the poll as a prediction of what individual physicians would be willing to accept – and this fact therefore actually *weakens* any argument that a poll would help payors to avoid wasted efforts. *See* discussion in Section V.C.2.b. Moreover, the fact that the poll results – whether actual predictors or not – were disclosed to *all* NTSP physicians encouraged them to reject price offers below the minimum fees indicated, Frech Tr. 1326-27, and NTSP actively encouraged them to reject the offers. *See* CX 1097 at 2; Vance Tr. 1215-18; Frech Tr. 1326-27. Finally, this disclosure of the poll results could also cause NTSP physicians to inflate their poll responses in subsequent years. *See* CX 430 (2002 annual policy form reminded physicians of prior year's averages); IDF 99-100. Thus, the poll results influenced the decisions of all NTSP physicians, regardless of whether they responded.

The manner in which NTSP utilized the minimum reimbursement schedule in its communications with payors also shows that it was using the poll for much more than just an administrative or efficiency-enhancing tool. For example, NTSP regularly informed payors that its physicians had established minimum fees for NTSP-payor agreements, identified the fee minimums, and stated that NTSP would not enter into or forward to any of its physicians payor offers that were below the minimums. CX 1196 (Van Wagner IH at 62-63, 153-54); CX 1173 (Deas IH at 26-29). This evidence is in stark contrast to the picture painted by Respondent about NTSP's activities associated with the poll, and

illustrates the need for a multi-faceted definition of price fixing called for in *Socony-Vacuum Oil.*

b. NTSP's Physician Participation Agreement

NTSP's physicians enter into a membership agreement (the PPA) with NTSP that grants NTSP the right to receive all payor offers and imposes on the physicians a duty to promptly forward payor offers to NTSP. CX 0276; CX 275 at 24. Essentially the PPA grants NTSP a right of first negotiation with payors. The physicians agree that they will refrain from pursuing offers from a payor until notified by NTSP that it is permanently discontinuing negotiations with the payor. CX 0276; CX 0311 at 10; CX 1178 (Hollander Dep. at 68). Under the PPA, NTSP is supposed to deliver payor price proposals (and other economic provisions of offers) for fee-for-service contracts to its physicians CX 0275 at 25-26.

We find that the PPA in effect renders NTSP as the sole bargaining agent of NTSP competing physicians and thus facilitates price fixing among NTSP physicians. The terms of the PPA and the manner in which NTSP has utilized them hinder the ability of payors to assemble a marketable physician network in the Fort Worth area without submitting to the collective bargaining of NTSP. Frech Tr. 1313-16.

Respondent argues that NTSP's PPA gives NTSP no authority to bind physicians, and that any non-risk contracts in which NTSP decides to join as a party must be messengered to the physicians for their own individual decisions on whether to join.

RAB at 8, 19. In addition, Respondent argues that the PPA's terms do not prevent a physician from negotiating with a payor directly or through another entity. *Id.* at 19.

We find that although the PPA requires NTSP to deliver contracts to its physicians, the evidence shows that NTSP rejects and does not deliver any contract that falls below its minimum reimbursement schedule. CX 1196 (Van Wagner IH at 68-69). Other terms of the PPA are inconsistent with Respondent's assertion that any non-risk contracts must be messengered. For example, the PPA contains provisions whereby 50 percent of NTSP's membership must approve the reimbursement proposal of a payor before an offer is "messengered" by NTSP to the physicians for actual opt-in/out of the proposed contracts.[32] CX 0276 at 1-2. This conduct has the potential to raise the level at which variability occurs, just as the use of polling data does.

We also find that each NTSP physician's ability to opt in or out of a contract – NTSP's inability to "bind" its members to a contract – does not eliminate the existence of a price-fixing agreement when providers collectively negotiate with payors over what contract terms will be offered. It is not necessary that there be uniform adherence to specific prices by individual members. In *Maricopa*, the Supreme Court found a price-fixing

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[32] The PPA contains another provision allowing for NTSP counter offers to payor rate proposals based on direction from at least 50 percent of NTSP's physicians. CX 0275 at 26.

agreement even though the participating physicians were free to set their own prices. 457 U.S. at 356. The Commission reached a similar result in *Motor Transport Ass'n of Connecticut, Inc.*, 112 F.T.C. 309, 336 (1989), stating that association members "need not agree to a single price level in order to fix prices."[33] In this case, NTSP is able to exert collective bargaining power and hence fix prices because NTSP does not messenger contracts below its minimum reimbursement schedule. Instead it rejects the contracts outright on behalf of its physicians and NTSP's collective bargaining leverage is thus exerted before its physicians even have a chance to opt in or out of a contract.

c. Powers of Attorney

In several instances, NTSP gathered powers of attorney from members whereby NTSP was appointed as their sole bargaining agent. CX 1173 (Deas IH at 56-57); CX 1065; CX 1061. We find that NTSP used its powers of attorney in a manner similar to the way it used the PPA, and the effect is the same – namely, to solidify its power as a bargaining agent and thus facilitate its price fixing. Jagmin Tr. 1058-60; Beaty Tr. 459-60; Frech Tr. 1327-30.

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[33] *See also In the Matter of Kentucky Household Goods Carriers Assoc., Inc.*, Docket No. 9309, 2005 WL 1541548 at *11 (FTC June 21, 2005), review pending, No. 05-4042 (6th Cir. Aug. 18, 2005); cf. *In re Petroleum Prods. Antitrust Litig.*, 906 F.2d 432, 445-50 (9th Cir.1990) (circulation of current price lists sufficient for liability, even without evidence of agreement to adhere to them), *cert denied*, 500 U.S. 959 (1991).

Respondent argues that this conduct is not evidence of concerted action, that the forms were limited in their application to "any lawful manner," and that NTSP used them only in conjunction with a messenger model.[34] RAB at 20. Respondent emphasizes that the powers of attorney did not commit a physician to accept or reject an offer, nor did they give NTSP any power to bind any physician on a non-risk contract. *Id.*

We find however, that the terms of the powers of attorney were clear on their face and improperly granted NTSP "authority to negotiate the terms of, enter into, execute, amend, modify, extend, or terminate" the relevant contracts. CX 347. To induce physicians to grant it powers of attorney, NTSP would include in its solicitations information about the number of physicians who already had executed the powers of attorney. CX 1066; CX 0548 at 1. NTSP physicians referred payors that were attempting to contract directly with them back to NTSP, often noting the deferral was based on agency or powers of attorney held by NTSP. Beaty Tr. 454-60, Grizzle Tr. 696-98, 724; CX 0760. Furthermore, NTSP advised payors in negotiations that it represented NTSP member physicians though powers of attorney or agency. Roberts Tr. 540-41. In one instance, NTSP sent Aetna a list of 180 physicians who had executed powers of attorney appointing NTSP as their bargaining agent for any direct contracting with Aetna. IDF 304. Unrebutted testimony from Aetna officials shows that Aetna understood this as a clear message that these

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[34] We discuss the "messenger model" arguments separately in Section V.B.1.e. below.

physicians would not negotiate directly with Aetna and therefore concluded that there was no practical alternative to dealing with NTSP. IDF 305-06.

d. NTSP's Concerted Withdrawals and Refusals to Deal Except on Collective Terms

In several instances NTSP used its agency powers to terminate its members' participation in a health plan or refused to deal with a payor because NTSP determined that the fee-for-service price paid by the payor was inadequate. CX 0546; CX 0802; CX 1054. For example, when NTSP was dissatisfied at one point during negotiations with United Healthcare Services, Inc., it terminated the United contracts of 101 physicians. IDF 147-54. On another occasion, after CIGNA sent contract assignment letters to Fort Worth physicians, in an attempt to contract with them independent of NTSP, NTSP provided its members with a sample letter refusing the contract assignment and directing CIGNA to negotiate with NTSP as their agent. IDF 205. NTSP advised its physicians not to consent to the assignment, and also sent them an agency agreement authorizing NTSP to negotiate on their behalf. IDF 205. Thereafter CIGNA received 40 letters on behalf of 52 physicians that were virtually identical to the sample letter provided by NTSP. IDF 206. On two other occasions, NTSP threatened to terminate its contract with CIGNA and then later actually terminated its contract, when terms were not satisfactory to NTSP. CIGNA was then forced to capitulate to NTSP's demands. *See* IDF 221-48. We find that NTSP illegally utilized refusals to deal and termination of contracts to enhance the bargaining

power of the participating physicians and command higher prices. Frech Tr. 1309-12; 1325.

Respondent argues, first, that NTSP's refusals to deal with payors are protected by the *Colgate* doctrine. RAB at 14-15, *citing United States v. Colgate & Co.*, 250 U.S. 300 (1919). This doctrine holds that a firm, acting unilaterally, may lawfully decide with whom it will, or will not, deal. *Colgate*, 250 U.S. at 307. Respondent views NTSP's refusals of payor offers as the lawful unilateral act of NTSP, and not the act of a group of horizontal competitors acting collectively through its agent, NTSP. RAB at 14-17. It reiterates for this purpose the familiar refrain that (1) NTSP does not have the ability to bind physicians, and (2) that each physician decides individually whether to accept a payor's offer. *Id.* Respondent also cites *Verizon Communications, Inc. v. Law Offices of Curtis v. Trinko, LLP*, 540 U.S. 398, 407-08 (2004), where the Supreme Court reaffirmed the *Colgate* doctrine, and warned that overly zealous enforcement of the antitrust laws can injure competition and innovation. Respondent argues that this admonition should apply to NTSP's refusals to deal. RAB at 15.

Second, Respondent argues as a policy matter that NTSP needs the ability to refuse contracts because it faces potential liability when it becomes a party to a payor contract. RAB at 16. Respondent explains that failure to perform obligations under a contract, involvement in illegal payor conduct, and involvement in deficient medical care can all subject NTSP to liability. *Id.* Further, Respondent states that NTSP has a reputation to protect and

involvement in a contract with poor performance can damage NTSP's reputation. *Id.* at 16-17.

We hold that *Colgate* is inapplicable in this case because NTSP's refusals to deal are not the unilateral acts of a single entity but rather are the collective action of all its independent physician members. NTSP's inability to bind members, and the ability of NTSP physicians to reject payor offers does not preclude the conclusion that NTSP has agreed to fix prices. There is a distinction between NTSP's simple refusal to provide services itself and NTSP's refusal to provide services on behalf of the physicians it represents.[35] NTSP was not acting unilaterally but in concert with its physician members. NTSP's conduct therefore does not fall within the bounds of *Colgate*, and the *Trinko* case is similarly not relevant.[36]

NTSP's further claim that its conduct is a necessary protection against liability and loss of reputation is reminiscent of the agreement that was rejected out of hand in *National Society of Professional Engineers*, 435 U.S. 679, and is entirely without factual support. NTSP itself does not need to

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[35] *See Indiana Fed'n of Dentists*, 476 U.S. at 465 ("That a particular practice may be unlawful is not, in itself, sufficient justification for collusion among competitors to prevent it . . . .") (*citing Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457, 468 (1941)).

[36] *Trinko* involved conduct by a single firm charged with monopolization under Section 2 of the Sherman Act, not with "contract, combination or conspiracy" under Section 1 of the Sherman Act. *Trinko*, 540 U.S. at 407. Unlike this case, there was no allegation that the defendant in Trinko had agreed with others to fix prices or refuse to deal.

engage in price fixing to protect itself from liability and loss of reputation.[37] The conduct challenged in this matter does not have anything to do with this type of potential liability, and the evidence shows that NTSP's refusals to deal were motivated by concerns about price and not liability and reputation. For example, NTSP's former president Dr. Vance summarized NTSP's success in its negotiations with United in a letter to his medical group, writing "United Health Care came to town six months ago and offered a straight, 110% of Medicare contract. . . . Through the efforts of NTSP lobbying the City [of Fort Worth] and terming [terminating] a group contract with Health Texas, United blinked. . . . This United negotiation is a template for other efforts that will need to occur in the near future and would best be coordinated by NTSP." CX 0256; *see also* CX 1199 (Vance Dep. at 316-17). Equally compelling is the fact that once payors have capitulated to NTSP's price demands, NTSP's objections disappeared. *See, e.g.*, IDF 242-48. NTSP's statements and its conduct show an overarching concern over price and not other contractual terms.

e. NTSP's Deviations from the "Messenger Model"

Respondent argues that once it decided to become a party to payor contracts it followed the so-called "messenger model" specifically described in *Health Care Statement* 9C, and hence that its

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[37] NTSP can communicate with its physicians on non-economic terms of a contract without price fixing. Frech Tr. 1450.

actions were lawful. RR at 16; *see* CX 387 at 1; CX 393 at 1; CX 186; CX 1075 at 2; CX 1122. After review of the evidence as a whole, we find that Respondent has deviated from the accepted parameters of a lawful messenger model in a manner that amounts to horizontal price fixing.

There is a wealth of guidance available on this subject. In addition to the discussion in the *Health Care Statements*, at least ten past Commission consents describe conduct that deviated from a lawful messenger model.[38]

Properly used, a messenger model is an arrangement designed to reduce transaction costs associated with negotiation of contracts between providers and payors; it is not a device for facilitating horizontal agreements among providers on prices or price-related terms. In a messenger model, a physician network uses the agent to convey

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[38] *See, e.g., In the Matter of Partners Health Network, Inc.*, Docket No. C-4149 (Analysis of Agreement Containing Consent Order, issued Aug. 5, 2005), http://www.ftc.gov/os/caselist/0410100/0410100.htm; *In the Matter of San Juan IPA, Inc.*, Docket No. C-4142 (Analysis of Agreement Containing Consent Order, issued May 19, 2005), http://www.ftc.gov/opa/2005/05/sanjuan.htm; *In the Matter of Preferred Health Servs., Inc.*, Docket No. C-4134 (Analysis of Agreement Containing Consent Order, issued Mar. 2, 2005), http://www.ftc.gov/opa/2005/03/scdoctors.htm; *In the Matter of White Sands Health Care System, L.L.C.*, Docket No. C-4130 (Analysis of Agreement Containing Consent Order, issued Sep. 28, 2004), http://www.ftc.gov/os/caselist/0310135/0310135.htm; *In the Matter of Southeastern New Mexico Physicians IPA, Inc.*, Docket No. C-4113 (Analysis of Agreement Containing Consent Order, issued June 7, 2004), http://www.ftc.gov/os/caselist/0310134/0310134.htm

to payors information obtained individually from the providers about the prices or price-related terms that the providers are willing to accept, but the agent does not negotiate on behalf of the providers. The agent may convey to the providers all contract offers made by purchasers, and each provider then makes an independent, unilateral decision to accept or reject the contract offers. Alternatively, the agent may receive authority from individual providers to accept contract offers that meet certain criteria as long as the agent does not negotiate on their behalf. The agent can also assist providers to understand the contracts offered, by supplying objective or empirical information about the terms of an offer. For example, the agent may provide a comparison of the offered terms with other contracts agreed to by network participants. On the other hand, it would be dangerous for the agent to express an opinion on the terms offered. *See Health Care Statements, supra* note 2, *Statement* 9C.

If a messenger model is used improperly, it can facilitate an unlawful price-fixing agreement. In a legal messenger model, the agent only facilitates independent, unilateral decisions of the network providers. *Id.* It is illegal to use the messenger model in a way that creates or facilitates collective decisions on prices or price-related terms.

It is necessary to look at specific facts on a case-by-case basis, because there is not necessarily any single feature that determines the outcome. Some examples of activities that can tip the balance toward illegality are: agent coordination of provider responses to a particular proposal, dissemination to network providers of the views or intentions of other

network providers about the proposal, expression of an opinion on the adequacy of price terms offered, collective negotiation of price terms for the providers, or decisions not to convey an offer if the agent believes the price terms are inadequate. *Id.* A fundamental question is whether the actions of the messenger are designed to facilitate communications or, instead, to enhance the bargaining power of the providers.[39]

It is important to remember that any time an agent for a group of competitors engages in any discussions that tinge on the prices they will charge, the parties are in an antitrust danger zone. The so-called messenger model, described in the *Health Care Statements*, provides what the agencies believe is a legal path though this danger zone, but it is dangerous to stray off the route. It is not enough for a physician association simply to claim that it has intended to follow the indicated path; it must show that it actually has done so.

NTSP's refusal to messenger contracts where it determined, based on the results of its prospective price poll, that less than 50 percent of NTSP

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[39] There are other widely available materials describing the proper use of a messenger model. For example, in 1997, the American Medical Association's Associate General Counsel advised that a messenger "may develop a schedule showing what percentage of physicians in the network would accept offers at various fee levels" but that "the messenger may not share this information with physicians," may not negotiate with a payor over fees to be offered to network participants, and "may not decide to forgo an offer because it is too low." Edward Hirshfeld, *Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks*, 6 ANNALS HEALTH L. 1, 29 (1997).

physicians would join, eliminates the ability of NTSP physicians to decide unilaterally whether to accept the un-messengered contracts and hinders the ability of payors to contract individually with NTSP physicians.[40] We also find that NTSP's PPA, use of powers of attorney and activities associated with its poll, discussed above, are inconsistent with an acceptable use of the model. The PPA and powers of attorney allowed NTSP to negotiate on behalf of its physicians, something expressly forbidden in a proper messenger model. The poll and minimum-fee schedule enabled NTSP to coordinate physician responses to payor proposals. NTSP also went beyond the bounds of legitimate messenger activities when it expressed its opinion both to its physician and to the payors themselves on the adequacy of price terms in contract proposals. *See Health Care Statements, supra* note 2, *Statement* 9C.

2. The Inherently Suspect Legal Analysis

The restraints described above, as a whole, are what we describe as inherently suspect under *Polygram*. The conduct itself can be said to have a likely tendency to suppress competition because the likelihood of anticompetitive effects from NTSP's restraints is sufficiently grounded in economic theory and supported in case law. Complaint Counsel's expert, Professor Frech, explained the economic rationale for the legal concerns about NTSP's conduct. Frech Tr. 1315-24. Through the mechanisms described above, NTSP was able to

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[40] *Cf.* Section V.C., which discusses the ability of an agent to charge a reasonable fee for these offers that are unlikely to be accepted.

collectively set prices and present its physicians as a unified and strong force within Fort Worth. These practices reduce the risk that payors would be able to contract around NTSP, and thereby enhance NTSP's bargaining power over price. Frech Tr. 1325-27; Grizzle Tr. 730, 746-47, 750-51. Because NTSP physicians comprise a large percentage of physicians in Fort Worth, their threat to withhold services severely damages the perceived adequacy of a payor's physician network, and makes it more difficult for a payor to obtain or maintain business. Grizzle Tr. 730-31; Jagmin Tr. 1091-92; Mosely Tr. 139-40. Payors are therefore more willing to pay the NTSP physicians' consensus price because of the threat to their physician networks. Grizzle Tr. 730, 746-47, 750-51; Frech Tr. 1325. NTSP itself summarized the concern succinctly: "NTSP has become a 'gorilla network' with 124 PCP's . . . and 528 specialists." CX 0209 at 2; CX 0310. Conduct that confers on competitors a collective power over price falls within the classic definition of price fixing.

Respondent argues that the Supreme Court's *California Dental* opinion prevents the Commission from condemning NTSP's conduct without a full rule of reason analysis. Respondent's first point in this argument is simply a reiteration of a claim already considered in another context. Respondent says that because there was no direct collusion among physicians,[41] NTSP's conduct meets *California Dental's* threshold test for determining that a "quick

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[41] As pointed out in Section V.A. above, the fact that the doctors did not communicate among themselves, but rather acted through a common agent, does not affect liability.

look" rule of reason analysis is not appropriate.[42] RAB at 28-29. Respondent adds that a quick look rule of reason analysis is appropriate only in limited circumstances, when it can be shown that "the great likelihood of anticompetitive effects can be easily ascertained." *Id.* at 29 (*citing California Dental*, 526 U.S. at 771). Because there was no direct collusion among NTSP physicians, Respondent states that the only possible candidates for a quick look under *California Dental* are the PPA provision requiring physicians to notify NTSP of payor offers that they receive directly, and the powers of attorney. *Id.* Respondent further argues that because both of these have plausible procompetitive effects, NTSP's conduct must be judged under a full rule of reason. *Id.*

The first problem with Respondent's argument is that it depends on the faulty conclusion that there was no collusion among NTSP's physicians, simply because they did not directly communicate with each other. As discussed above in Section V.A., the physicians combined in other ways and their conduct can be characterized as price fixing. Moreover, *California Dental* essentially involved collective restrictions on advertising, not on the prices charged. The Court observed that the advertising restrictions in question were "very far from a total ban on price or discount advertising."

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[42] We have used "inherently suspect" in *Polygram* and in this opinion to refer to conduct that may be justified in some circumstances but, absent these circumstances, can be condemned without an extensive demonstration of adverse market effects in the case at hand. We believe this level of inquiry is what the Supreme Court means by a "quick look."

California Dental, 526 U.S. at 773. The threshold question in *California Dental* was whether the likelihood of anticompetitive effects from restrictions on professional price and quality advertising was sufficiently verifiable in theory and in fact to fall within a general rule of illegality. *Id.* at 771. The Court determined that the restrictions were, at least on their face, designed to avoid false or deceptive advertising in a market characterized by striking disparities between the information available to the professional and the patient. *Id.* Indeed, the Court expressed concern that "the particular restrictions on professional advertising could have different effects from those 'normally' found in the commercial world," *id.* at 773, and that "[t]he obvious anticompetitive effect that triggers abbreviated analysis has not been shown." *Id.* at 778. Unlike *California Dental*, this case involves prices, not advertising; the challenged conduct therefore has the necessary "obvious anticompetitive effect," and not something "very far" removed from it.

B. Respondent's Justifications

Respondent's justifications in this case are intermingled with its arguments about the existence of an agreement. *See generally* RAB at 14-18, 28-34, 45-57. We have attempted to sort them out into separate categories, for clarity.[43]

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[43] Our analysis here deviates somewhat from Complaint Counsel's proffered analysis. Complaint Counsel's arguments against Respondent's proffered justifications are couched in terms of whether NTSP's price fixing was ancillary to any significant productive collaboration among its participating physicians. As we mentioned above in Section IV.A., the doctrine of ancillary restraints is subsumed in the

1. Teamwork and Spillover Efficiencies

Respondent argues that its risk panel physicians "use financial and clinical integration techniques to develop team-oriented improvements in cost and quality." RAB at 49. Respondent further argues that NTSP has a right to "limit" its involvement to non-risk contracts that will be of interest to most of its risk panel physicians, so that their participation will ensure the spillover of the efficient treatment patterns established in the risk contract. *Id.* We interpret Respondent's use of the word "limit" as intended to explain and justify its particular activities associated with its PPA, powers of attorney, refusals to deal and deviations from the messenger model. Respondent also argues that NTSP's poll and board minimums are tools that allow NTSP to identify when a non-risk offer will be of interest to most of its physicians, and therefore help it to enhance the spillover effects. *Id.* at 50.

We first do not accept Respondent's premise that NTSP's poll and efforts to "limit" NTSP's involvement to certain non-risk contracts are justified because they will help NTSP to determine

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Polygram analysis. (The *Polygram* methodology can also be used more broadly to deal with justifications of a different kind. It could be applied, for example, in a case like *Broadcast Music*, 441 U.S. at 20-25, where the argument was that the system could not function at all without collective agreement on price terms, or *United States v. Brown University*, 5 F.3d 658, 677 (3d Cir. 1993), where agreements on student aid could be characterized as pro-competitive overall.) When we use the terminology of *Polygram* rather than the terminology of ancillary restraints, it does not mean that we disagree with Complaint Counsel's alternative analysis.

when spillover efficiencies are likely to occur. *Id.* at 48-50. The prices NTSP sets through the minimum reimbursement schedule were not prices sought by risk panel doctors, but instead were averages of the members who responded, which includes non-risk doctors. IDF 51, 87, 89-90, 93. NTSP's Board members and senior management were never informed of individual poll responses; they received only aggregated, average results, which did not reveal to what extent risk panel physicians were likely to participate in non-risk contracts.[44] IDF 94-95. Although these limitations may be prudent, they undercut an argument that the minimum reimbursement schedule could help NTSP determine when spillover efficiencies would occur. As discussed above, it is evident that the poll and limitations were designed for another purpose. *See* discussion in Section V.B.1.a.

Respondent has thus failed to articulate a logical nexus between these activities that facilitate price fixing and the claimed efficiencies. As we stated in *Polygram*, a defendant must do more than merely assert that its purported justification benefits consumers. Although the defendant need not produce detailed evidence at this stage, it must articulate the specific link between the challenged restraint and the purported justification to merit more searching inquiry into whether the restraint may advance procompetitive goals, even though it

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[44] Respondent even emphasized in its appeal brief that "it is impossible for [anyone] to determine the response of any specific physician or speciality, or even to determine whether they responded." RAB at 24.

facially appears of the type likely to suppress competition.

Polygram Comm'n Op., supra note 4, at 31-32.

This conclusion is reinforced by the statement of NTSP's executive director, Karen Van Wagner. During an investigational hearing when she was asked the question whether reimbursement rates at or above NTSP's contracting minimums were necessary in order for NTSP to achieve clinical integration, she testified:

> I think it's the other way around. We've achieved a certain degree of clinical integration. We've achieved a certain level of medical management. We've achieved a certain amount of cost savings, satisfaction, quality of care for the members. That basically is reflected in the rates that we ask the payors to give us because that's the value we provide them, so I view it the other way around. Clinical integration is necessary to justify the minimums that the members authorize us to go and try and find.

CX 1196 (Van Wagner I-H at 145-46). We explained in *Polygram* that "a defendant cannot defend restraints of trade on the ground that the prices the conspirators set were reasonable, that competition itself is unreasonable or leads to socially undesirable results." *Polygram Comm'n Op., supra* note 4, at 30-31. There is no antitrust exception for particularly efficient, higher quality market participants: NTSP is not entitled to "pre-empt the working of the

market" to produce the result that it believes payors should choose. *Indiana Fed'n of Dentists*, 476 U.S. at 462. Individual non-risk physicians might well be able to command higher fees from payors if they can promise superior outcomes, but this superior efficiency alone would not justify the exercise of collective bargaining power.

There are additional flaws in the spillover efficiency claim. Respondent does not explain how the NTSP physicians who only enter into non-risk contracts could achieve spillover efficiencies from NTSP's single risk contract. This is a non-trivial point, because non-risk physicians make up half of NTSP's members. Van Wagner Tr. 1830; Frech Tr. 1349. Furthermore, NTSP does not even explain why its risk panel physicians will have the incentive to apply the quality and cost control techniques they utilize on risk patients to any non-risk patients they may have. NTSP has not provided any financial incentive for them to do so, and it does nothing to promote compliance with whatever techniques have been learned under risk contracts. IDF 364-80; Deas Tr. 2553-54. NTSP does not employ the processes it uses to monitor and control the quality and utilization of services provided under its risk contracts to patient care provided under non-risk contracts. IDF 364-80; Deas Tr. 2550-54.

We also note that Respondent's counsel admitted that risk contracts are out of favor in Fort Worth, Texas. O.A. at 23; *see also* Wilensky Tr. 2192; IDF 46, 48. NTSP's actions, purportedly justified as efforts to enhance spillover efficiencies from its one risk contract, seem to be perceived by customers merely as an attempt to regulate the terms of access

to the more- desired non-risk product. *See generally* Frech Tr. 1349. This justification is inconsistent with the procompetitive aims of the antitrust laws and is not cognizable.

It is worth noting that we are not challenging NTSP's sole risk contract, which involves financial integration, but which NTSP's Board has acknowledged "is a small part of the business." CX 83 at 3. Moreover, Respondent does not make the argument that NTSP's non- risk contracts are sufficiently clinically integrated, as described in *Health Care Statement* 8B, to justify an in-depth rule of reason inquiry. In fact, Respondent all but admits that its administration of these contracts does not constitute clinical integration as commonly understood – *e.g.*, exchange of clinical information, coordination of treatment, development of protocols and monitored compliance. *See, e.g., MedSouth, supra* note 2, at 4-6. Indeed, NTSP's president, Ms. Van Wagner, stated that "NTSP isn't 'there yet' in terms of clinical integration for the care of nonrisk patients."[45] Van Wagner Tr. 1877.

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[45] Respondent argues instead that the concept of clinical integration does not encompass the full scope of conduct that is justifiable under the rule of reason, and that NTSP's "teamwork" yields sufficient cost and quality benefits. RAB at 51. We do not decide here whether there are potential justifications beyond what the Commission has accepted as "clinical" integration in the past. But Respondent's claim that NTSP's "teamwork" yields cognizable cost and quality benefits simply is not supported by significant evidence. Moreover, Respondent does not address how these nebulous "teamwork" efficiencies are dependent on its price-fixing activities.

2. The PPA, Powers of Attorney, Refusals to Deal and Refusals to Messenger Contracts

Respondent also argues that NTSP's PPA notice provision, its use of powers of attorney, its communications with physicians and payors, and its refusal to messenger contracts have plausible procompetitive effects on their own. RAB at 45-57. The PPA ostensibly increases NTSP's contracting opportunities in the marketplace by informing NTSP of new contract opportunities. *Id.* at 30. The powers of attorney ostensibly were gathered by NTSP to inform it of which and how many physicians were willing to be messengered an offer through NTSP. RAB at 31. Respondent also argues that disclosure to physicians that NTSP will not be involved in a particular payor offer will alert physicians that they need to look to other contracting avenues with payors in those situations. RAB at 33.

In addition, Respondent claims that when it informs physicians about a payor's conduct or the status of a payor offer, it is merely collecting and disseminating market information.[46] *Id.* at 34, 53. Respondent states that the procompetitive effects of information sharing in the health care industry, even among competing physicians, is recognized by Complaint Counsel's economic expert and the Commission's advisory opinions. *Id.* Respondent also

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[46] Respondent also states that NTSP's comments to a payor about the terms that physicians might find attractive or reasonable can help to educate the payor and expedite contract negotiations. RAB at 34. For reasons discussed in Section V.D. *infra*, this kind of activity is not necessarily suspect.

states that its refusal to convey payor contract offers with prices that NTSP believes are not sufficiently high to attract a majority of its participating physicians is efficient because a physician network has a plausibly valid concern about resources wasted if it were to transmit a payor's offer that is of interest to less than 50 percent of the physicians. *Id.* at 32.

The problem with these arguments is that most efforts by competitors to collectively agree on prices could be said to save costs in negotiations with customers. (Similarly, an agreement to allocate markets is likely to reduce selling expenses.) Arguments of this kind ultimately are based on the idea that competition itself is inefficient, and are thus not cognizable under the antitrust laws.[47] We explained in *Polygram* that "[c]ognizable justifications ordinarily explain how specific restrictions enable the defendants to increase output or improve product quality, service, or innovation." *Polygram* at 30. A justification will fail, however, if it contradicts the procompetitive aim of the antitrust laws. *Id.*

These purported justifications are also inconsistent with the evidence. As discussed above in Section V.B.1., the evidence shows that NTSP's overriding purpose in each of these activities was to exploit its collective bargaining leverage over payors, not to achieve efficiencies. For example, Respondent's assertion that NTSP helps physicians

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[47] *See, e.g., Maricopa*, 457 U.S. at 346; *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 689-90; *Goldfarb*, 421 U.S. at 786-87.

to determine when they will need to communicate with payors in other ways (because of NTSP's refusal to deal) is absurd in light of the fact that NTSP routinely cautioned its physicians not to undermine NTSP solidarity and its pricing consensus. In an "Open Letter to the Membership," NTSP's Dr. Vance stated, "[w]e must continue to move forward as a group or we will surely falter as individuals." CX 0550. In another letter, NTSP warned its physicians that fees will decline unless "NTSP or someone can provide a unifying voice for physicians."[48] CX 0380 at 3. NTSP also implicitly urged its physicians to delay or forgo direct contracting during NTSP's negotiations with payors.[49] These actions are designed to enhance bargaining clout, not to increase efficiency from spillover effects, or to conserve resources, or to spread procompetitive benefits of information sharing.

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[48] *See also* CX 0380 at 2 (informing its members that through "direct" negotiation or affiliation with other IPAs, NTSP obtained prices "5 to 15% over Tarrant County rates"); CX 0550 (stating to members that it "has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source").

[49] *See, e.g.,* CX 0310 (Dr. Deas advising NTSP physicians that "discussions are ongoing with Aetna U.S. Healthcare, Cigna, and other major players which should lead to contracts that are more favorable than we would be able to achieve individually or though other contracting entities"); NTSP regularly sent "fax alerts" to its members and held "General Membership Meetings" to continually provide contracting updates for specific payor negotiations and share NTSP's poll results with the membership CX 1178 at 21-23 (Hollander Dep. at 2123); CX 0173 – CX 0180; CX 0182 – CX 0188; CX 0615; CX 0945; CX 0903; CX 0617; CX 0628; *see also* Frech Tr. 1326-27.

3. Denial of Discovery Request in Support of Purported Justification

Respondent argues that the ALJ erroneously denied NTSP's discovery request for the payors' "flat file" data that would show how NTSP and other physicians performed on non-risk contracts. RAB at 45-46. Respondent claims that, without these files, it has limited capability to show how NTSP's performance compares to other physician providers. *Id.* Respondent also states that PacifiCare and Cigna had provided NTSP with some information in the normal course of business which showed that NTSP is the best performing group in the Dallas/Fort Worth Metroplex and that spillover from care under capitated contracts occurs. *Id.* at 46 n.190.

We find that the ALP s denial of the discovery request was not detrimental to Respondent. In the absence of a specific link between the challenged restraints and the purported justification, it would not have mattered if Respondent had been able to obtain further discovery and demonstrate that its physicians performed well. There is no antitrust exemption for more efficient, higher quality market participants, absent a demonstration that the challenged practices made an essential contribution to these efficiencies.[50] Evidence on the performance

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[50] *See, e.g., Broad. Music*, 441 U.S. at 23-24 (declining to find blanket license fee plan *per se* illegal where plan contributed to integration of sales, monitoring, and enforcement against unauthorized copyright use); *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 693-95 (rejecting petitioners argument that preventing inferior work justified anti-competitive agreement).

of NTSP physicians, standing alone, would not prove that nexus.

C. Potentially Permissible Conduct

Although we have rejected the proffered justifications for NTSP's particular activities, we do not want this opinion to be read so broadly that it would chill potentially efficient practices. We do not question that NTSP's risk contract and its physicians who participate in it achieve efficiencies, and it could even be possible for these efficiencies to spillover to its non-risk contract in certain circumstances. As we discussed above in Section IV, if an IPA can establish that its joint negotiation of price is reasonably related to an efficiency-enhancing integration of the participants' economic activity and is reasonably necessary to achieve the procompetitive benefits of that integration, the price-related activities may be lawful. A good example of this is described in the Commission staff's advisory opinion letter to MedSouth, Inc., a multi-specialty physician practice association in Denver, Colorado.[51]

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[51] Another example is *In the Matter of California Pacific Medical Group, Inc.*, Docket No. 9306 (consent order issued May 11, 2004), http://www.ftc.gov/os/adjpro/d9306/index.htm, where Commission staff advised California Pacific Medical Group, Inc., d/b/a Brown & Toland Medical Group, that as of that time they would not recommend action against a clinically-integrated PPO product that Brown & Toland Medical Group created after entering into a consent order with the Commission. *See* Advisory Opinion Letter from Daniel P. Ducore, Esq. and David R. Pender, Esq., FTC, to Richard A. Feinstein, Esq., Boies, Schiller & Flexner, LLP (Apr. 5, 2005), http://www.ftc.gov/os/adjpro/d9306/050405cpbresponsetbthotice.pdf.

Commission staff did not object to MedSouth's partial integration proposal that included joint negotiation for the sale of its participating physicians' services to payors on a fee-for-service basis. *MedSouth, supra* note 2, at 1, 8-9. Commission staff concluded that MedSouth could plausibly produce sufficient procompetitive effects to justify joint negotiations of fees. *Id.* at 1, 8. This conclusion was based on the extensive clinical resource management program that MedSouth developed for its participating physicians, and that was described in detail in the advisory opinion letter. *Id.* at 2-4, 8. It is also noteworthy that MedSouth did not plan to negotiate contracts on behalf of its physicians until after the operational plan was fully functioning.[52] *Id.* at 4.

NTSP admittedly is not even close to having the efficiency-enhancing processes that MedSouth had committed to have before it began to negotiate for its physicians collectively. For example, NTSP has no disease management program or patient register that would improve health care quality for

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[52] For example, MedSouth developed a web-based electronic clinical data record system that allows MedSouth physicians to access and share medical information relating to their patients, including transcribed patient records, office visit notes, lab reports, radiographic reports, treatment plans, and prescription information. *MedSouth, supra* note 2, at 3. This system could be expected to increase efficiencies by reducing duplicative testing and procedures, expediting treatment, and decreasing medical errors and adverse drug interactions. *Id.* Also important was MedSouth's plan to adopt and implement clinical practice guidelines and performance goals relating to the quality and appropriate use of services provided by its physicians. *Id.* MedSouth had in place a plan to monitor and enforce physician compliance with the guidelines. *Id.* at 3-4.

patients with specific, long-term conditions. Casalino Tr. 2812-14, 2839; Van Wagner Tr. 1834-36. NTSP has no data for patients under its fee-for-service contracts, and NTSP's hospital utilization management program does not apply to patients under its non-risk contracts. Casalino Tr. 2868-69; Frech Tr. 1352-53; Van Wagner Tr. 1837-38. Furthermore, NTSP does not require adherence to its clinical guidelines and protocols. Van Wagner Tr. 1843-44; *see also* Casalino Tr. 2837-39, 2840.

There could also be lawful ways for an association like NTSP to utilize some of the mechanisms discussed above, even without clinical or financial integration. NTSP could, for example, have lawfully polled its members on future fees in order to give payors a sense of the fee levels that would be acceptable to a majority of NTSP physicians, provided that (1) the results of the poll were not communicated back to the physicians in any manner, to avoid influencing their behavior; (2) NTSP did not use the polling results as a basis for determining which payor offers it would elect to messenger to the physicians; and (3) NTSP did not use the polling results to negotiate price with payors. *See Health Care Statements, supra* note 2, *Statement* 5B. NTSP could also lawfully charge an administrative fee to payors to compensate for the burden of messengering contracts that were unlikely to be accepted. For example, if a contract contained rates that were below the rate a threshold percentage of physicians were likely to consider acceptable based on the polling data, NTSP could impose a reasonable transmittal fee (to reimburse the association for an incremental burden, not to signal disapproval). If a payor refused to pay the fee

in these situations NTSP could legally refuse to messenger the contract.[53]

Note that these modified practices would not be justified on the ground that they contribute to efficiency of medical practice in the same way that integration does. They rather contribute to the efficiency of the contract negotiation process itself. Because they are not designed to enhance the bargaining power of the physicians, they are not suspect in the first place. They are benign even in the absence of integration.

NTSP can also act as a messenger so long as it adheres to legal standards, which the antitrust agencies have attempted to summarize in the *Health Care Statements*. As discussed above, a key to a lawful messenger model is that the IPA must refrain from using prospective polling results in determining which payor offers it would elect to messenger, and refrain from any activity that amounts to influence over physicians, negotiations on their behalf and coercion of payors. NTSP can also review and comment on non-economic terms of a contract. Furthermore, NTSP can utilize powers of attorney or agency agreements in a manner that does not facilitate a price-fixing agreement. For example, a power of attorney could legally authorize NTSP to

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[53] *See* Advisory Opinion Letter from Jeffrey W. Brennan, Esq., FTC, to Martin J. Thompson, Esq., Manatt, Phelps & Phillips, L.L.P. (Sept. 23, 2003), http://www.ftc.gov/bc/adops/bapp030923.htm. (Commission staff did not object to a physician IPA proposal to refuse to administer contracts where fewer than 50 percent of the physicians accept, unless the payors agree to bear the group's contract administration costs).

enter a contract on behalf of a physician when a physician's stated price minimum and other terms are met, so long as NTSP does not attempt to influence those key terms, or use powers of attorney to negotiate with a payor.[54]

There is also nothing inherently objectionable about physicians providing current price information to NTSP for a purpose that is unrelated to the actual establishment of prices. For example, NTSP physicians could agree collectively through NTSP to jointly adopt an electronic billing system that would permit them to run their offices more efficiently. If there are sufficient safeguards to shield the billing rates of individual physicians, the practice would not be suspect.

D. Necessity of Market Definition and Market Power

The ALJ held that it was necessary to define a relevant market, even when analyzing a *per se* unlawful price-fixing agreement. ID 61.[55] Complaint Counsel appeal the Initial Decision in part based on this conclusion, and argue that no proof of market definition or market power is required to establish a

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[54] We warn, however, that the distinction between lawful and unlawful use of powers of attorney or agency arrangements and the messenger model may require careful counseling. As evidenced by NTSP's conduct in this case, there are many different ways that a power of attorney or agency arrangement and the messenger model can be abused in a manner that facilitates price fixing.

[55] Although Complaint Counsel did not define the market, the ALJ found sufficient evidence to do so on his own. ID at 61-64.

per se violation, *citing Socony-Vacuum Oil*, 310 U.S. at 221-22. CCAB at 35-36. Respondent argues that the rule of reason requires that the market must be defined in this case and that Complaint Counsel would have had this burden even in a *per se* case, *citing California Dental* and the Initial Decision. RAB at 36.

As made clear in the discussion above, we find that proof of market definition and market power is *not* required in this case because Respondent did not meet its burden of establishing a legitimate justification for NTSP's inherently suspect practices. The ALJ may have confused *identification* of a market in which anticompetitive effects are presumed to occur with *definition* of a relevant market in order to measure market share and draw inferences about market power. As we stated in *Kentucky Household Goods Carriers*, "[i]t is obviously necessary to identify the goods or services that are subject to the price-fixing or other anticompetitive restraint . . . [i]t is not necessary, however to show that these goods or services constitute a relevant antitrust product market, as described, for example, in the *Horizontal Merger Guidelines*." *Kentucky Household Goods Carriers*, Docket No. 9309, 2005 WL 1541547 at * 11.[56] The

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[56] In fact, even in a full blown rule of reason case, it may not be necessary to calculate shares in a relevant market if more direct evidence of market effects is available. *See Indiana Fed'n of Dentists*, 476 U.S. at 460-61; *In the Matter of Schering-Plough Corp.*, Docket No. 9297, 2003 WL 22989651, at *9,11,13 (F.T.C. Dec. 8, 2003) (citations omitted), *rev'd on other grounds, Schering-Plough Corp. v. F.T.C.*, 402 F.3d 1056 (11th Cir. 2005), *petition for cert. filed* (U.S. Aug. 29, 2005) (No. 05-273).

restraints in *Kentucky Household Goods Carriers* were found to be illegal *per se*, but this distinction does not matter. As we have explained above in Sec. M.A., if a practice is either *per se* illegal or inherently suspect, the focus is on the nature of the conduct, not the nature of the market. If there is no legitimate justification for the practice, there is no need for a burdensome inquiry into market conditions. *See FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 433-36 (1990). Simply put, it makes no sense to undertake the exercise of market definition if it will not affect the outcome in any way.

Respondent also argues that Complaint Counsel submitted no empirical evidence in this case to prove NTSP's market power, or to prove that NTSP's conduct caused an anticompetitive effect in any market. RAB at 35- 44. Respondent asserts that NTSP does not have market power and that the numerous avenues through which physicians could and did contract undermine the possibility that any market power existed. *Id.* at 40-41. The ALJ found that NTSP did not receive higher rates than those that other physicians and physician groups were already receiving. ID at 82. The ALJ found only that NTSP obtained higher rates or more beneficial economic terms than the health care payors initially offered to NTSP. *Id.* at 82-83. Respondent states that this has no antitrust significance in the absence of a showing that physicians entered into a boycott conspiracy, because NTSP as an entity can choose to participate or not in a payor offer. RAB at 42-43. Furthermore, Respondent argues that Complaint Counsel's focus on physician rates totally ignores the cost and quality effects of patient care, which are

more accurate measures of competitive performance. *Id.* at 43-44.

We agree that higher physician rates, by themselves, are of no antitrust significance. They may indeed be associated with higher quality of care or with different competitive conditions in various localities. Evidence that payors increased their initial offers similarly is ambiguous, standing alone. Those matters are not what this case is all about; this case is about a concerted effort by NTSP's participating physicians to increase their bargaining power. As discussed above, because Respondent did not meet its burden to establish a legitimate justification for this inherently suspect conduct, NTSP's conduct can be condemned with no further analysis under *Polygram* and other authorities.

VI. Remedy

The Commission has wide discretion in its choice of a remedy for violations of Section 5 of the FTC Act. *FTC v. Nat'l Lead Co.*, 352 U.S. 419, 428 (1957); *Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611 (1946). This discretion includes not just the prohibition of the illegal practice in the manner exercised in the past, but also so-called "fencing-in" relief, which refers to provisions in an order that are broader in scope than the conduct that is declared unlawful. Fencing-in relief is deemed necessary in some cases in order to prevent future unlawful conduct.[57] The Commission's remedy, however, must

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[57] *See, e.g., FTC v. Colgate-Palmolive Co.*, 380 U.S. 374, 395 (1965); *Kraft, Inc. v. FTC*, 970 F.2d 311, 326-27 (7th Cir. 1992).

be reasonably related to the violation. *FTC v. Ruberoid Co.*, 343 U.S. 470, 473 (1952); *Jacob Siegel*, 327 U.S. at 613.

In this case, we have the benefit of the Commission's extensive experience in crafting appropriate remedies for physician IPAs that have engaged in conduct similar to that of NTSP. Over the years the Commission has fine tuned the relief necessary to prevent future illegal conduct in these cases. To the extent order provisions in these cases have proved ineffective or unnecessary, the Commission has appropriately modified them. The order we impose in this case – which was proposed by Complaint Counsel and is somewhat different than the ALJ's order – is consistent with recent past relief accepted in settlement in similar cases, and is based on the Commission's extensive experience. We are therefore confident that the relief will effectively remedy NTSP's illegal conduct and is neither too narrow nor too broad. Our order is designed to protect the public against any further violations by NTSP, but also to allow NTSP to pursue arrangements that may produce efficiencies without significant risk of anticompetitive consequences.

As usual, Paragraph I of the order defines terms that will be used, and Paragraph II contains general prohibitions against participation in or facilitation of a conspiracy among any physicians. It specifically prohibits agreements to "negotiate"[58]

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[58] Although our order does not define the term "negotiate," we intend it to incorporate the distinctions described in *Health Care Statements* 4 and 5 between the lawful provision of factual information and views to payors (as

with any payor on behalf of physicians or to refuse to deal on their behalf. A proviso to Paragraph II, however, allows NTSP to engage in "qualified" risk-sharing or clinically-integrated arrangements, and even to set prices for its physicians' services when doing so is reasonably necessary to the joint arrangement.

In a "qualified clinically-integrated joint arrangement," as defined by the order in Paragraph I.I., physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. Any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement. In a "qualified risk-sharing joint arrangement," also defined by the order (Paragraph I.J.), all physician participants must share substantial financial risk in order to create incentives for the physician participants jointly to control costs and improve quality. In both cases, any agreements on price or other terms must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

Paragraph III of the order allows NTSP to act as a messenger or an agent on behalf of physicians for contracts with payors, but for three years NTSP is required to notify the Commission in advance

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in a true messenger model) and efforts to enhance the collective bargaining power of the participating physicians.

before it does so. This prior notice provision is necessary because of NTSP's past deviations from the messenger model. We have accepted this type of prior notice provision in the past. Our order also requires NTSP to terminate any non-risk contracts it negotiated on behalf of its physicians, so NTSP does not continue to benefit from its unlawfully negotiated contracts. Paragraphs IV.B. and C. set forth the terms by which NTSP is required to terminate the contracts, and additional related requirements. The remaining provisions of our order are either administrative in nature, or relate to NTSP's requirement to notify affected persons of the existence of the order. They impose little burden on NTSP. The order terminates after twenty years.

Respondent argues that the ALF s order is not narrowly tailored to any antitrust violation properly found. Respondent first asserts that because there was no collusion among physicians, the ALJ's order is not supported in the record. It claims, for example, that because NTSP has the right to negotiate its own contracts, the remedy cannot prohibit NTSP from negotiating contracts. And because there was no collusion among the physicians, it says termination of NTSP's existing physician contracts is not warranted. RAB at 60-62. Respondent also argues that, as worded, prohibitions on NTSP's role in payor negotiations with physicians (particularly on information exchanges among physicians) would apply to non-price as well as price terms and thus conflict with *Health Care Statements* and applicable law. *Id.* at 62.

Respondent's arguments essentially restate their rejected claim that there have been no

violations. We find that the prohibitions on collective negotiation and the need to terminate existing contracts are both "reasonably related" to NTSP's unlawful conduct. We also find that the ban on collective bargaining through the use of non-price terms as well as price terms is necessary to ensure that NTSP does not seek to perpetuate its unlawful conduct by orchestrating agreements through non-price or non-economic terms. We also find that it is necessary to terminate NTSP's contracts, so that NTSP's physicians do not continue to reap the benefits of their unlawful price fixing. Even though the contracts are already terminable at will, mandatory termination is necessary to avoid the risk that payors might fear retaliation or suffer short-term competitive disadvantage if they voluntarily terminate a contract with NTSP. The Commission has used similar or broader fencing-in relief in other physician price-fixing cases.[59]

We find that the ALJ's order is inappropriately narrow in some of its core provisions and therefore fails to provide adequate protection against further violations. Paragraph II of the ALJ's order omitted provisions proposed by Complaint Counsel that would have prohibited agreements on

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[59] *See, e.g., In the Matter of Partners Health Network, Inc.*, Docket No. C-4149 (consent order, issued Aug. 5, 2005), http://www.ftc.gov/os/caselist/0410100/0410100.htm, (order requires prior notice for three years before Partners Health Network, Inc. can participate in a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement); *In the Matter of New Millennium Orthopaedics, LLC*, Docket No. C-4140 (consent order, issued May 2, 2005), http://www.ftc.gov/opa/2005/06/fyi0543.htm, (order requires dissolution of IPA).

terms of dealing with payors (*i.e.*, without regard to whether there is any agreement to "negotiate") and collective refusals to deal with payors. These limitations were based on the ALJ's view that a prohibition of agreements to refuse to deal would impose on NTSP a broad duty to contract with all payors. ID at 89. The language in our order does not mandate that result. The provisions in question have never been interpreted in that manner in numerous other orders that contain them. These provisions only prohibit conduct by NTSP "in connection with the provision of physician services." Any services provided by NTSP itself that are not directly related to the provision of physician services would not be covered and NTSP would not be forced to contract. As long as NTSP's conduct does not amount to an agreement among physicians to refuse to deal, NTSP will have the ability to refuse certain contracts.[60] Complaint Counsel have proposed the addition of the phrase "with respect to their provision of physician services" and a new definition of "physician services" in order to further clarify the point. CCAB at 64-65. We have incorporated Complaint Counsel's proposed clarification.

Paragraph II of the ALJ's order failed to include language proposed by Complaint Counsel that would have prohibited agreements that physicians not deal individually with payors or through entities other than NTSP. We find that this is an important provision to include in this case

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[60] As noted above, NTSP even has the ability to act as a "messenger" under the order. If Respondent complies with the standards for this activity, described in Section V.B.1.e. above, there would not be an order violation.

because NTSP facilitated a price-fixing agreement through its physicians' agreement not to deal individually with payors while NTSP was conducting its own negotiations on their behalf *See* Section V.B.1.b. above.

The ALJ's order also contains two unwarranted provisos to Paragraph II of the order that could enable NTSP to continue its illegal conduct: (1) a statement that nothing in the order bars NTSP from "communicating purely factual information" about a payor offer or "expressing views relevant to various health plans,"[61] and (2) a provision stating that nothing in the order would "require respondent to violate state or federal law." ID at 94. We find that neither of the provisos is necessary to protect legitimate conduct by NTSP.[62] The communication of "purely factual information" is already covered by Paragraph III, which allows NTSP to act as a messenger and, given Respondent's

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[61] The ALJ also limited the scope of a provision barring information exchanges. Paragraph II.B. of the ALJ's order prohibits the exchange of information about the terms on which physicians are willing to deal with a payor, but does not include a prohibition on exchange of information about a physician's willingness to deal with a payor. We have included this prohibition in past physician price-fixing Commission orders and believe it should be included in this order. NTSP was able to orchestrate its unlawful price-fixing scheme in part by communicating that its physicians were unwilling to deal with payors in certain situations.

[62] Nearly anything could be termed providing "information" and "views." For example, NTSP's announcement that its physicians will not contract with payors at prices below a certain level could be characterized as conveying factual "information" or as an "expression of views."

history, we believe that advance notification is necessary for a period of time. In addition, because we have found that there is no basis for a claim that NTSP's refusals to deal were prompted by concerns over violations of law, we do not believe it is prudent to leave the door open for similar unfounded claims in the future. There is nothing in the order we enter that will require Respondent to engage in illegal activity.

Respondent finally argues that Complaint Counsel's proposed changes to the ALJ's order raise serious policy questions about the Commission's agenda on physician teamwork efforts. RR at 24. Respondent states that Complaint Counsel's order will chill legitimate conduct on NTSP's part in response to illegal conduct and breaches of contract by insurance companies, and will discourage teamwork efforts among physicians which do not fit the currently narrow definitions of risk-sharing or clinical integration. *Id.* at 31. Respondent also points out that it is difficult to find any economic evidence that the Commission's enforcement agenda has had any positive economic effect, in the effort to control total medical expenses. Respondent states that any Commission policy to arbitrarily limit innovation is questionable. *Id.* at 36-37.

Respondent's arguments here misunderstand the Commission's role in this industry. We have a responsibility to prosecute antitrust offenses, but, as stated at the outset, we also should foster pro-competitive, innovative delivery mechanisms for health care in this country. NTSP's illegal conduct has not helped it achieve any efficiencies. Our order, which proscribes only conduct used to carry out

NTSP's unlawful price-fixing activities, will not inhibit any efforts to achieve efficiency and innovation though the teamwork or other integration of physicians. We describe in Section V.D. above the many constructive activities that an IPA can undertake, consist with the antitrust laws. And as noted above, Paragraph II of our order allows NTSP to engage in legitimate joint arrangements and even set prices for its physicians' services, but only when doing so is reasonably necessary to achieve the efficiencies of the joint arrangement.

VII. Conclusion

For all of the reasons outlined above, we conclude that NTSP's contracting activities with payors amount to unlawful horizontal price fixing. Through the various mechanisms described above, NTSP was able to orchestrate price agreements among its physicians. In physician IPA cases like this one, the focus is not necessarily on any single price-fixing mechanism, but rather on the conduct as a whole. Here the evidence shows not only negotiation activity in aid of a collective agreement on a minimum fee schedule, but also specific enforcement mechanisms – such as the powers of attorney and collective withdrawal from payor networks – in order to coerce agreement from payors. These actions viewed as a whole leave no doubt that the overriding purpose behind NTSP's conduct was to fix prices.

This is not really a close case. NTSP's conduct is similar to conduct that has been held *per se* unlawful and summarily condemned in other contexts. For the reasons stated, we have analyzed the conduct under our more flexible *Polygram*

framework, and considered each of Respondent's defenses in depth. Our ultimate conclusion is the same.

Date News Release Issued: December 1, 2005
Date of Decision: November 29, 2005
Date of Oral Argument: July 18, 2005

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

DOCKET NO. 9312

In the Matter of

NORTH TEXAS SPECIALTY PHYSICIANS,

Respondent.

INITIAL DECISION

D. Michael Chappell
Administrative Law Judge

Date: November 15, 2004

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I. INTRODUCTION

A. Summary of Decision

This is a horizontal price fixing case. The Federal Trade Commission ("FTC") charges that Respondent North Texas Specialty Physicians ("NTSP"), on behalf of its participating physicians, collectively bargained with health insurance plans in order to obtain higher prices or more favorable economic terms in contracts for physician services.

Respondent NTSP is an independent practice association ("IPA") of approximately 500 physicians, the vast majority of whom are specialists who practice in Fort Worth, Texas. NTSP physicians are a significant presence and make up a large percentage of practitioners in many specialities in the Fort Worth area. One the functions of NTSP is to receive offers from health insurance plans of Health Maintenance Organization ("HMO") or Preferred Provider Organization ("PPO") contracts ("non-risk contracts") to provide physician services in the Fort Worth, Texas area. Upon receipt of a payor offer of a non-risk contract, Respondent evaluates the offer and determines whether to send it — messenger it — to its participating physicians. Respondent does not messenger to its physician members any offers on non-risk contracts that fall below minimum rates established by the NTSP Board ("Board minimums"). NTSP establishes Board minimums by conducting polls among its physician members that ask each physician to disclose the minimum price that he or she would accept to provide medical services pursuant to a non-risk contract.

In its defense, Respondent asserts that it did not negotiate economic terms of non-risk contracts. Respondent further asserts that it is entirely proper for Respondent to determine whether or not to send contract offers it receives from health care members to the physicians who participate in NTSP.

The government proved its case. As explained in detail in the findings of fact and analysis below, the evidence establishes that physicians participating in NTSP, who are otherwise competitors of each other, communicated to NTSP the minimum prices that they were willing to accept for physician services and that NTSP used this information to negotiate higher rates and more favorable terms for non-risk contracts than those initially offered by various health insurance plans. Through the use of price information collected from its physician members to leverage increased offers or better terms from health insurance payors, NTSP has engaged in a combination, contract, or conspiracy that has unreasonably restrained trade. Accordingly, Complaint Counsel has demonstrated a violation of Section 5 of the FTC Act. The appropriate remedy is an order to cease and desist.

B. Summary of Complaint and Answer

The FTC issued its Complaint in this matter on September 16, 2003. The Complaint charges that Respondent, acting as a combination of competing physicians, has restrained competition by negotiating and entering into agreements among its participating physicians on price; refusing or threatening to refuse to deal with payors except on collectively agreed upon terms; negotiating fees in payor contracts for NTSP's participating physicians;

and refusing to submit payor offers to participating physicians unless and until price and other competitively significant terms conforming to NTSP's contract standards have been negotiated. Complaint ¶12. The Complaint further alleges that the acts of Respondent have had the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Fort Worth area in the following ways: price and other forms of competition among NTSP's participating physicians were unreasonably restrained; prices for physician services were increased; and health plans, employers, and individual consumers were deprived of the benefits of competition. Complaint ¶23. The Complaint charges that the combination, conspiracy, acts, and practices alleged in the Complaint constitute unfair methods of competition in or affecting commerce in violation of Section 5 of the Federal Trade Commission Act, as amended, 5 U.S.C. § 45. Complaint ¶24.

In its Answer, filed on October 7, 2003, Respondent denied the material allegations of the Complaint and asserted the following defenses: that it is a memberless non-profit corporation and therefore is not subject to the jurisdiction of the Federal Trade Commission; that NTSP's conduct does not constitute commerce as defined in the Federal Trade Commission Act; that NTSP has the right as an entity under *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919) to refuse to become a party to another's contract or transaction; and that NTSP's conduct has been fair, reasonable, and justified. Answer p. 3.

C. Procedural Background

On March 2, 2004, Complaint Counsel filed a Motion for Partial Summary Decision. Also on March 2, 2004, Respondent filed a Motion for Summary Decision. Respondent's motion was denied by Order dated April 9, 2004. Complaint Counsel's motion was denied by Order dated April 14, 2004. Both motions were denied on the ground that genuine issues of material fact raised by the pleadings could only be properly determined after an evidentiary hearing.

The final prehearing conference was held in Fort Worth, Texas on April 27, 2004. Trial commenced immediately following the prehearing conference. Nearly 1,500 exhibits were admitted and 17 witnesses testified, either live or by videotape. Trial concluded on May 25, 2004.

On June 16, 2004, both parties filed proposed findings of fact, post trial briefs, and conclusions of law. Complaint Counsel filed its response to Respondent's brief and proposed findings of fact on June 30, 2004, and filed a corrected response to Respondent's proposed findings of fact on July 1, 2004. Respondent filed its response to Complaint Counsel's brief and proposed findings of fact on June 30, 2004. Closing arguments were heard on July 21, 2004.

The hearing record was closed pursuant to Commission Rule 3.44(c) by Order dated June 8, 2004. Rule 3.51(a) of the Commission's Rules of Practice states that an Initial Decision shall be filed "within ninety (90) days after closing the hearing record pursuant to § 3.44(c) . . . or within such

further time as the Commission may by order allow upon written request from the Administrative Law Judge." 16 C.F.R. § 3.51(a). Ninety days from the close of the record was September 7, 2004. By Certification for Extension of Time to File Initial Decision dated August 25, 2004, the Commission was requested to extend the time for filing this Initial Decision by sixty days, until November 8, 2004. By Order dated September 17, 2004, the Commission granted this request and extended the date for filing the Initial Decision until November 8, 2004.

Rule 3.51(a) also states that an Initial Decision shall be filed within one year "after the issuance of the administrative complaint, except that the Administrative Law Judge may, upon a finding of extraordinary circumstances, extend the one-year deadline for a period of up to sixty (60) days." 16 C.F.R. § 3.51(a). The Complaint in this matter was issued on September 16, 2003. One year from the issuance of the Complaint was September 16, 2004. By Order dated September 14, 2004, extraordinary circumstances were found to extend the one-year deadline for a period of up to sixty days, until November 15, 2004.

D. Evidence

This Initial Decision is based on the exhibits properly admitted in evidence, the transcript of trial testimony, and the briefs, proposed findings of fact and conclusions of law, and replies thereto submitted by the parties. Citations to specific numbered Findings of Fact in this Initial Decision are designated by "F."

Under the Commission's Rules of Practice, a party or a non-party may file a motion seeking in camera treatment for material, or portions thereof, offered into evidence. 16 C.F.R. § 3.45(b). The Administrative Law Judge may order that such material be placed *in camera* only after finding that its public disclosure will likely result in a clearly defined, serious injury to the entity requesting *in camera* treatment. 16 C.F.R. § 3.45(b). Pursuant to Commission Rule 3.45(b), several orders were issued granting *in camera* treatment to material that met the Commission's strict standard. In addition, when the parties sought to elicit testimony at trial that revealed information that had been granted *in camera* treatment, the hearing went into an *in camera* session.

In instances where a document or certain trial testimony has been given *in camera* treatment, but the portion of the material cited to in this Initial Decision does not rise to the level necessary for *in camera* treatment, such material is disclosed in the public version of this Initial Decision, pursuant to Commission Rule 3.45(a) (the ALJ "may disclose such *in camera* material to the extent necessary for the proper disposition of the proceeding"). *In camera* material that is used in this Initial Decision is indicated in bold font and braces ("{ }") in the *in camera* version; it is redacted from the public version of the Initial Decision, in accordance with 16 C.F.R. § 3.45(f).

This Initial Decision addresses only material issues of fact and law. Proposed findings of fact not included in this Initial Decision were rejected, either because they were not supported by the evidence or

because they were not dispositive or material to the determination of the allegations of the Complaint or the defenses thereto. The Commission has held that Administrative Law Judges are not required to discuss the testimony of each witness or all exhibits that are presented during the administrative adjudication. *In re Amrep Corp.*, 102 F.T.C. 1362, 1670 (1983). Further, administrative adjudicators are "not required to make subordinate findings on every collateral contention advanced, but only upon those issues of fact, law, or discretion which are 'material.'" *Minncapolis & St. Louis Ry. Co. v. United States*, 361 U.S. 173, 193-94 (1959).

II. FINDINGS OF FACT

A. Background

1. Organization of and contracting by physician practices

1. Physicians often organize their practices into medical groups, which operate as single integrated entities having a single CEO, accountant, office manager, and staff. (Casalino, Tr. 2795-96).

2. Physicians and medical groups often contract with health plans in order to increase the volume of patients available to them. (Frech, Tr. 1288-89).

3. Competing physicians and medical groups sometimes enter into arrangements with others to form independent practice associations, known as IPAs. IPAs are looser combinations of medical groups formed for the purpose of negotiating

contracts with managed care health plans. (Casalino, Tr. 2796; Frech, Tr. 1292).

4. IPAs generally lack direct authority to control the practices of their member physicians. (Casalino, Tr. 2799-2800).

2. Health care insurance and managed care

5. Historically, most health care insurance coverage was indemnity insurance. The prevalence of indemnity insurance skewed incentives in such a way that consumers often neither sought to reduce price by seeking lower-priced providers, nor quantity by seeking to avoid over-utilization. (Frech, Tr. 1282-83).

6. Managed care was introduced to address these deficiencies and control the cost of health care services through health plan contracting with physicians, control of utilization, and management of care. (Frech, Tr. 1282-84, 1289).

7. One form of managed care is the Health Maintenance Organization ("HMO"). HMOs generally feature small provider panels, low co-payments for patients, and broad administrative controls to limit utilization, with no coverage for patients who choose providers outside the network. (Frech, Tr. 1283-84).

8. HMO contracts can involve a variety of physician compensation structures. In some instances, participating physicians are paid a stated fee for each service rendered. This compensation

structure is referred to as fee-for-service. (Mosley, Tr. 131-32).

9. A less tightly controlled form of managed care is the Preferred Provider Organization ("PPO"). Relative to HMOs, PPOs generally involve fewer administrative controls and higher patient co-payments to limit utilization, but larger physician panels and greater access to out-of-network physicians, albeit at a reduced rate of reimbursement. (Frech, Tr. 1283-84).

10. The Medicare RBRVS fee schedule is Medicare's Resource Based Relative Value System ("RBRVS"), a system developed by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for each service rendered to Medicare patients. (Frech, Tr. 1286; Wilensky, Tr. 2144).

11. Health plans that contract with physicians on a fee-for-service basis often do so based on a stated percentage of the Medicare RBRVS fee schedule, which provides reimbursement rates for a large number of specific procedures. (Frech, Tr. 1286; Mosley, Tr. 137; Grizzle, Tr. 692-93).

12. The Medicare RBRVS establishes weighted values for each medical procedure, such that the application of a percentage multiplier (such as 100% for Medicare itself), enables one to determine the fees for thousands of different services simultaneously. (Frech, Tr. 1286).

3. Distinction between risk and non-risk agreements

13. In a risk sharing agreement ("risk contract"), sometimes referred to as a capitation agreement, physicians participating in an HMO are paid (or share) a set dollar amount stated per member, per month, irrespective of the quantity of services rendered. (Frech, Tr. 1293; Mosley, Tr. 131-32; Wilensky, Tr. 2177-78).

14. Capitation agreements shift the risk of overutilization of medical services to the capitated physician or physician group. (Quirk, Tr. 255; Mosley, Tr. 206; Lovelady, Tr. 2638). Physicians respond to capitation and other incentive systems by modifying their utilization and other practice patterns. (Fresh, Tr. 1293-94; Casalino, Tr. 2811; Lovelady, Tr. 2640-41).

15. In a non-risk sharing agreement ("non-risk contract"), physicians are paid under a fee-for-service reimbursement arrangement. (CX 1177 (Grant, Dep. at 78); CX 1198 (Vance, Dep. at 36)). In fee-for-service arrangements, physicians do not bear the risk of overutilization of physician services because payments are made for the services provided. (Frech, Tr. 1346-47).

16. PPOs generally utilize non-risk sharing agreements where the insurance company contracts to reimburse providers at a predetermined level for services performed by the physicians. (Mosley, Tr. 134).

B. North Texas Specialty Physicians

1. Organization and composition

17. NTSP is an IPA located in Fort Worth, Texas. (CX 311 at 1; CX 1196 (Van Wagner, 08.29.02 IHT at 8)). It is a nonprofit corporation organized, existing, and doing business under and by virtue of the laws of Texas, with its office and principal place of business at 1701 River Run Road, Suite 210, Fort Worth, Texas, 76107. (Complaint ¶1; Answer ¶1; RX 1674 (NTSP fact sheet)).

18. NTSP does not function as a clinically integrated organization for patients seen under non-risk contracts. (Casalino, Tr. 2877).

19. NTSP was formed in 1995 under section 5.01(a) of the Texas Medical Practice Act, which allows nonprofit entities to engage in the practice of medicine for the purposes of research, medical education, or the delivery of health care to the public. (Van Wagner, Tr. 1489-90; RX 1674; RX 1675; RX 1676).

20. NTSP carries on business for the pecuniary benefit of its member physicians. (CX 311 at 10-11 and CX 275 at 30-31 ("NTSP shall use its best efforts to market itself and its Participating Physicians to Payors and to solicit Payor offers for the provision of Covered Services by Participating Physicians"); CX 310 (stating that NTSP physician's ability to negotiate "substantially improved" by NTSP; noting NTSP's discussions with payors "should lead to contracts that are more favorable than we would be able to achieve individually or through other contracting entities"); CX 159 at 2

(noting contractual issues addressed by NTSP include "maintaining minimal reimbursement standards for its member physicians")).

21. NTSP, as an organization, receives its revenue from risk contracts and a one time fee of $1,000 from each physician. (Van Wagner, Tr. 1552).

22. From January 1, 1999 to December 22, 2003, NTSP purchased $1,047,819.86 from vendors with billing addresses outside of Texas. (CX 1203; CX 1195 (Van Wagner, 01.20.04 Dep. at 77)). For example, NTSP purchased $457,373.09 of stop loss insurance from McPhee & Associates, a California insurance broker. (CX 1203; CX 1195 (Van Wagner, 01.20.04 Dep. at 81)).

23. NTSP's Board of Directors ("Board") is made up of eight physicians. Under NTSP's organizational documents and under Texas law, NTSP's directors, other than an "Officer Director," must be physicians who are actively engaged in the practice of medicine. (CX 275 at 7; Van Wagner, Tr. 1493-94; *see also* TEX. OCC. CODE ANN. § 162.001 (Vernon 2004)).

24. The Board of Directors is elected from among NTSP's member physicians and meets once a week. (Van Wagner, Tr. 1493-94).

25. NTSP has a salaried, core administrative staff of eight people, including executive director Karen Van Wagner, provider relations staff, provider sponsored network ("PSN") development and contracting staff, data processing

staff, credentialing staff, and clerical support staff. (Van Wagner, Tr. 1494-95; RX 1674).

26. NTSP's Medical Executive Committee includes the chairs of each of NTSP's specialty divisions who are elected by the member physicians within each specialty. (Deas, Tr. 2559-60; CX 275 at 5).

27. Karen Van Wagner, Ph.D. is NTSP's executive director. Van Wagner joined NTSP in 1997, roughly a year after the organization was established. (Van Wagner, Tr. 1461-62).

28. Dr. Thomas Deas is the current president and chairman of the Board of NTSP. In addition to heading the Medical Executive Committee, Deas is a medical director of NTSP. (Deas, Tr. 2524, 2556).

29. Dr. William Vance was one of the founding members of NTSP, serving as its president from 1996 until 2001. Vance was a member of the Medical Management Committee from its inception through 2002. In addition, he was the chairman of NTSP's cardiology section. His role within NTSP ceased when his practice group, Consultants in Cardiology, withdrew from NTSP in April 2002. (CX 1198 (Vance, Dep. at 9, 48, 49)).

30. Dr. John Johnson, III is a medical physician and a current member of NTSP's Board of Directors. (CX 1182 (Johnson, Dep. at 6, 13)).

2. Member physicians

31. NTSP has member physicians in eight counties in and around the Dallas/Fort Worth Metroplex. (Van Wagner, Tr. 1468-69). Approximately 85-88% of NTSP's member physicians are located in Tarrant County, with the majority located in Fort Worth. (Van Wagner, Tr. 1471; CX 1196 (Van Wagner, 08.29.02 IHT at 15-16)).

32. At the time of trial (April 2004), NTSP had approximately 480 participating physicians. (Van Wagner, Tr. 1510, 1518). In 2003, NTSP had approximately 575 participating physicians, practicing in 26 different specialties, who had signed NTSP's Physician Participation Agreement ("PPA"). (CX 311 (physician participation agreement); RX 3118 (Maness Report ¶¶4, 19)). In 2001, NTSP had as many as 652 physicians. (CX 209 at 2 ("NTSP has become a 'gorilla network' with approximately 124 PCP's [primary care physicians] . . . and 528 specialists.").

33. NTSP member physicians attend general membership meetings, pay dues, and elect NTSP's Board. (CX 1178 (Hollander, Dep. at 21-24, 34)).

34. NTSP member physicians are organized into specialty divisions, based on field of practice. (Van Wagner, Tr. 1510).

35. NTSP's member physicians have distinct economic interests, reflecting their separate clinical practices. (CX 1182 (Johnson, Dep. at 21); *see also* CX 524 (roster of NTSP member physicians

listing multiple physicians and/or physician groups practicing the same specialty in Fort Worth)).

36. Many NTSP physicians and physician practices are in competition with one another. (CX 1182 (Johnson, Dep. at 21) ("We compete for patients. We compete at the different hospitals at which we work."); CX 550 (noting that NTSP's disagreements with payors were supported by its membership despite the fact that "short term advantage and perceived best interest are always controversial and potentially divisive, weakening the strength that our numbers provide.")).

3. Overview of NTSP's functions

37. NTSP was founded in 1995 to allow a group of specialist physicians to accept economic risk on medical contracts and to participate in the medical decision-making process. NTSP has since broadened its activities to include entering into and messengering non-risk contracts and has expanded its membership to include primary care physicians ("PCPs"). (RX 1675; Vance, Tr. 587-88; Wilensky, Tr. 2158-59).

38. The Board manages the organization, determines NTSP's minimum contract prices, and evaluates contract offers. If a payor offer is at or above Board minimum rates (*infra* F. 83-90) and is otherwise acceptable, NTSP will messenger the offer to its member physicians. (CX 275 at 5; Van Wagner, Tr. 1642-43; Vance, Tr. 595-96; CX 1177 (Grant, Dep. at 22-24); CX 1174 (Deas, Dep. at 42)).

39. NTSP represents its member physicians and provides administrative expertise to

review contracts, confront timely payment issues, and lobby government agencies for physician issues. NTSP has evolved into a forum for its member physicians to cooperate and discuss the general and specific business of medicine and receive advice and information. (CX 350).

40. NTSP's Medical Executive Committee transmits information and feedback, including the status of fee-for-service contract discussions, between NTSP's staff and Board and the membership. (CX 1174 (Deas, Dep. at 20-21); Deas, Tr. 2560).

41. NTSP communicates with its member physicians by sending faxes called "Fax Alerts" which keep its member physicians informed of the activities of NTSP, including contractual issues. (CX 1178 (Hollander, Dep. at 48); CX 1198 (Vance, Dep. at 54)).

42. NTSP holds "general membership meetings" to provide contracting updates for specific payor negotiations and to discuss and share NTSP's poll results with the membership. (CX 1178 (Hollander, Dep. at 21-23); CX 182; CX 183; CX 184; CX 186; CX 187).

4. Contracts with health insurance providers

43. NTSP "is in the business of contracting with health maintenance organizations, health care networks and other payors to provide health care services through physicians and physician groups who have contracted with NTSP to provide health

care services. (CX 311 at 1 (WHEREAS Recital of NTSP PPA)).

44. One of NTSP's functions is to negotiate reimbursement terms in contracts with health plans on behalf of NTSP's member physicians. (CX 159 at 2 ("Contracting issues addressed by NTSP this past year included maintaining minimal reimbursement standards for its physicians."); CX 350 ("NTSP was started in an attempt to provide a seat at the table of medical business for the individual specialty physicians .... NTSP, through PPO and risk contracts, has provided a consistent premium fee-for-service reimbursement to the members when compared with any other contracting source."); CX 1182 (Johnson, Dep. at 10-11) ("NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups to hopefully be able to secure contracts, improve patient care, and provide a voice at the table for physicians. . . . [It was] to represent physicians . . . in obtaining contracts from businesses or insurance companies or in dealing with hospitals.")).

45. NTSP analyzes contract language from both operational and legal perspectives, communicating with payors about the terms of the contract, determining the payor's payment policies and timing, mailing contracts to participating physicians, determining when physicians accept a given contract, and establishing and updating systems to track physician and plan member participation in a given contract. (Van Wagner, Tr. 1648-49; Wilensky, Tr. 2195-96; RX 3118 (Maness Report ¶76); CX 1196 (Van Wagner, 08.29.02 IIIT at

56-57)). This review benefits physicians. (CX 1182 (Johnson, Dep. at 11) ("As a busy physician, I had relatively little time to look at contracts, and oftentimes did not understand the legal language in contracts, so having another organization that could review contracts and educate me as to the terms in the contracts" was a benefit.)).

46. NTSP originally focused on negotiating shared-risk contracting with health plans, but as the market moved away from risk-sharing arrangements, NTSP increasingly sought to negotiate and did negotiate non-risk contracts. (CX 195).

47. In 2001, NTSP accepted risk on only approximately 32,000 lives. (CX 616 at 2 (NTSP takes professional risk on approximately 20,000 commercial and 12,000 Medicare lives)).

48. In March 2001, NTSP's Board of Directors stated that "risk business is a small part of the business" and concluded that NTSP's "focus should center on how to benefit members on fee-for-service contracts as well." (CX 83 at 3).

49. NTSP has one risk-sharing contract — the one it shares with PacifiCare. (CX 1177 (Grant, Dep. at 19)). Within the past five years, NTSP also had a risk contract with AmCare. (CX 1196 (Van Wagner, 08:29.02 IHT at 14); CX 1195 (Van Wagner, 01.20.04 Dep. at 15)).

50. NTSP has approximately twenty fee-for-service contracts, covering many more lives. (CX 1196 (Van Wagner, 08.29.02 IHT at 14); *see also* CX

265, *in camera* (listing, by health plan, lives covered under NTSP's non-risk contracts)).

51. Sixty percent, of NTSP's physicians participate in fee-for-service contracts. Roughly half of those physicians participate in risk-sharing contracts. Some of these physicians participate in NTSP through a participation agreement under which they can gain access to NTSP's non-risk contracts, but are not eligible to participate in NTSP's risk contract. (CX 616 at 2-12; CX 1197 (Van Wagner, 08.30.02 IHT at 182, 228-29); Van Wagner, Tr. 1830; CX 1194 (Van Wagner, 11.19.03 Dep. at 37-38)).

C. Relevant Market

52. In contracting for health plan services, Fort Worth employers demand significant coverage by physicians who practice in the Fort Worth area and who admit patients to Fort Worth hospitals. (Grizzle, Tr. 688-89, 722; Frech, Tr. 1304-05; Mosley, Tr. 141-42; Quirk, Tr. 276-77, 280; Jagmin, Tr. 1104-07).

53. To be competitively marketable to Fort Worth area employers, health plans must include many physicians who practice in a variety of fields in the Fort Worth area. (Grizzle, Tr. 688-89, 720, 722; Jagmin, Tr. 1104-07).

54. When buying health coverage, employers look for networks that include all of the tertiary care hospitals in an area, most of the other hospitals within the area, and a broad selection of physicians in the locale, including a wide selection of

specialists within each specialty. (Jagmin, Tr. 971-72, 1102-03; Quirk, Tr. 270-72, 275-76).

55. Health plans try to assemble and market a panel of physicians that will satisfy employers' preferences for greater access to a wide array of conveniently located physicians, without compromising the overall cost of care. (Quirk, Tr. 270-72; Jagmin, Tr. 972).

56. Fort Worth employers typically would consider a network adequate if it had physicians within ten miles of at least 85%, and preferably 90%, of its employees. (Mosley, Tr. 141-42).

57. NTSP physicians agree that Fort Worth specialists are better able to address the needs of patients (and primary care physicians) located in Fort Worth than physicians located elsewhere. (*E.g.*, CX 583 at 1-2 (Johnson, an NTSP member physician, writing: "[o]bviously a provider network whose business is based entirely here in Fort Worth is better positioned to address the needs of both patients and physicians.") (*emphasis in original*). *See also* CX 1187 (McCallum, Dep. at 59) (NTSP Board member testifying that Dallas physicians compete in a different market than NTSP physicians)).

58. A large network of physicians located in Dallas or in the Mid-Cities, defined as the areas including Arlington, Hurst, Euless, Bedford, Colleyville, and Southlake (CX 1196 (Van Wagner, 08.29.02 IHT at 16), would not be marketable to Fort Worth employers if the network did not also have a large number of appropriate physicians located in

Fort Worth. (Mosley, Tr. 142-43; Jagmin, Tr. 1103-04; Quirk, Tr. 280-82).

59. A network of physicians located in Dallas or the Mid-Cities that did not also have a large number of appropriate physicians located in Fort Worth would not achieve the geographic access required by employers with large numbers of Fort Worth employees and would not be acceptable to employers, even if they were discounted by five or ten percent, relative to those areas. (Mosley, Tr. 142-43; Quirk, Tr. 279-80).

60. If all Fort Worth physicians increased prices by five percent, health plans serving Fort Worth employers would not be able to avoid the price increase by substituting away from Fort Worth. (Grizzle, Tr. 723; Quirk Tr. 280-82; Jagmin, Tr. 1103-04).

61. NTSP physicians are a significant presence in the Fort Worth area. NTSP physicians make up a large percentage of Tarrant County practitioners in several medical specialties: 80% for pulmonary disease, 68.6% for urology, and 58.8% for cardiovascular disease. (Frech, Tr. 1299). Tarrant County includes Fort Worth and several surrounding cities. (Quirk, Tr. 420; Maness, Tr. 1992).

62. A loss of NTSP's physicians from a health plan's network would have "a very deleterious affect" on the health plan's ability to market its product in Tarrant County. (Jagmin, Tr. 1091). One health insurance plan's representative testified that, without NTSP's physicians, it would suffer from significant holes in coverage for a number of specialties in Fort Worth. ({ }, *in camera*).

63. NTSP has stated that a health plan attempting to serve the employees of the City of Fort Worth "would not be able to satisfy employer/employee match or network access standards without NTSP Physicians Participating in the Network," and that, "NTSP is the only stable physician organization left in the Tarrant County market." (CX 1042. *See also* CX 576 at 3 (NTSP stating that "without NTSP specialists in the Aetna network, a severe network inadequacy problem will exist in Fort Worth.")).

D. Contract, Combination, or Conspiracy

1. Physician Participation Agreement

64. NTSP and its participating physicians enter into the Physician Participation Agreement ("PPA"), establishing their relationship. (CX 276 at 1).

65. The PPA grants NTSP the right to receive all payor offers and imposes on the participating physicians a duty to promptly forward those offers to NTSP. (CX 276 (Fax Alert stating that NTSP shall have "exclusive right, on behalf of its members, to receive all payor offers"); CX 275 at 24 ("NTSP shall have the right to receive all Payor Offers made to NTSP or Physician . . . If Physician receives a Payor Offer, . . . Physician will promptly forward such Payor Offer to NTSP for further handling in accordance with the provisions of this Agreement.")).

66. The PPA grants NTSP a right of first negotiation with payors, with each physician

agreeing that he or she will refrain from pursuing offers from a health plan until NTSP notifies them that NTSP is permanently discontinuing negotiations with the health plan. (CX 275 at 2; CX 276; CX 311 at 8; Deas, Tr. 2405-06; CX 1178 (Hollander, Dep. at 68) ("And there were various criteria like time limits that the participating physician[s] generally agreed that they would just wait and after that time limit was expired, then they were free to negotiate on their own.")).

67. With respect to "Non Risk Payor Offers," the PPA states:

> [p]romptly after receiving any Non Risk Payor Offer, NTSP shall deliver to Physician and each other Participating Physician the Fee Schedule and other economic provisions of the Non Risk Payor Offer. Physician shall have ten (10) business days within which to accept or reject such Fee Schedule and economic provisions, with the understanding that if Physician fails so to accept or reject within such 10-day period, Physician shall be deemed to have accepted such Fee Schedule and economic provisions.
>
> If the Participating Physicians who approve and who are deemed to have approved the Non Risk Payor Offer constitute 50% or more of all Participating Physicians, then NTSP, on behalf of Physician, shall notify the Payor of the acceptance and proceed

with negotiation and execution of a Payor Agreement.

If 50% or more of the Participating Physicians request that NTSP submit a counter-proposal to the applicable Payor, then NTSP shall submit the counter-proposal to such Payor. If the counter-proposal is accepted, then NTSP, on behalf and as agent of Physician, shall proceed with negotiation and execution of a Payor Agreement with respect to such counter-proposed offer.

If the counter-proposal is not accepted by the Payor but the Payor submits its own counter-proposal, then such counter-proposal shall be treated as a new payor offer and will be submitted to Participating Physicians in accordance with the preceding provisions.

(CX 275 at 25-26).

68. Although under the PPA, NTSP is obligated to deliver to each physician the fee schedule and other economic provisions of a non-risk payor offer (CX 275), NTSP delivered only those offers which were approved by NTSP and which met minimum levels established by the Board, as determined by the results of a poll. (Van Wagner, Tr. 1706; CX 1196 (Van Wagner, 08.29.02 IHT at 29-30) (the Board does not send to physicians offers below the minimal acceptable level as determined by the results of a poll.)).

69. With respect to "Payor Offers Rejected by NTSP," the PPA states:

> If NTSP rejects any Payor Offer and advises the Participating Physicians in writing that it is permanently discontinuing negotiations or if the Participating Physicians who approved and who are deemed to have approved a Non Risk Payor Offer constitute less than 50% of all Participating Physicians, then NTSP shall have no further responsibilities with respect thereto and any Participating Physician shall have the right to pursue such Payor Offer on its own behalf.

(CX 275 at 26).

70. NTSP has urged its member physicians to avoid undermining NTSP's role in negotiating contracts on behalf of its member physicians. (*E.g.*, CX 550 (Vance's "Open Letter to the Membership": "We must continue to move forward as a group or we will surely falter as individuals"); CX 380 at 3 (NTSP warning its physicians that physician fees will decline unless "NTSP or someone can provide a unifying voice for physicians"); CX 400 at 2 (NTSP warning its member physicians that without their support "it is likely NTSP will not be around the next time. Aetna, Cigna, or United come to town" with unsatisfactory rate proposals.)).

71. NTSP cannot and does not bind any member physician or physician group to non-risk

contracts. (Frech, Tr. 1362-64; Van Wagner, Tr. 1637, 1777).

72. NTSP's member physicians can and do contract with health plans outside of NTSP, either directly, through financially integrated physician groups, or through other IPAs. (Quirk, Tr. 288-89; Van Wagner, Tr. 1564, 1637; Deas, Tr. 2432).

73. There are no agreements between one or more NTSP member physicians to not participate in or to reject a non-risk payor offer. (Frech, Tr. 1365; Maness, Tr. 2048).

74. NTSP's member physicians and physician groups do not consult with each other when making decisions on non-risk payor contracts. (Maness, Tr. 2049-50).

75. NTSP's member physicians and physician groups do not know what any other physician or physician group will do in response to a non-risk payor offer. (Frech, Tr. 1436-37; Maness, Tr. 2044-46; Deas, Tr. 2423).

2. Power of attorney forms

76. In the process of negotiations with United Healthcare ("United") and with Aetna Health, Inc. ("Aetna"), NTSP has solicited and obtained power of attorney forms from its member physicians, giving NTSP the legal authority to negotiate non-risk contracts on behalf of those member physicians. (CX 1173 (Deas, IHT at 56-57); Palmisano, Tr. 1250-51. *E.g.*, CX 347 at 2; CX 1061 at 1).

77. The power of attorney forms that NTSP provided to its physicians with respect to contract negotiations with United and Aetna state:

> The undersigned . . . appoints, with full power of substitution, North Texas Specialty Physicians . . . as attorney-in-fact to act for me in any lawful way with respect to all contracts and agreements (including without limitation all prospective contracts or agreements) with and/or involving the undersigned and . . . [United Health Care / Aetna].
>
> This power of attorney grants to the agent the authority to act on the undersigned's behalf regarding the foregoing described agreements in all respects, including the authority to negotiate the terms of, enter into, execute, amend, modify, extend or terminate any such agreements.

(CX 1061-1103 (United); CX 347-404 (Aetna)).

78. In distributing the power of attorney forms to its member physicians, NTSP has instructed its physicians to inform health care payors' representatives that NTSP is his or her contracting agent and to instruct the health care payor to contact NTSP with respect to contracting activity. (CX 1066 (United); CX 548 (Aetna)).

79. NTSP also includes in power of attorney solicitations information about the number of physicians who already have executed the power of

attorney forms. (CX 1066 ("Thus far, NTSP has received 107 signed documents from NTSP member physicians assigning NTSP power of attorney to act on their behalf in regard to all contracting activity between themselves and United Healthcare."); CX 548 (NTSP sent 180 power of attorney authorizations in regard to Aetna HMO and PPO commercial products)).

80. With respect to negotiating with Cigna Healthcare ("Cigna"), NTSP requested its member physicians to sign an "authorization form" to allow NTSP to serve as its physicians' agent. (CX 332).

81. NTSP physicians have referred health plans that sought to contract directly with them back to NTSP, at times noting that the deferral was based on agency or power of attorney held by NTSP. (Beaty, Tr. 454-60; Grizzle, Tr. 696-98, 701, 709; CX 760 (exhibit admitted as an exception to the hearsay rule for verbal acts and not for the truth of the matter asserted therein ["limited admission"]). *See also* CX 1178 (Hollander, Dep. at 116) ("[I]f an NTSP physician had signed an agency agreement specifying that NTSP was to be their exclusive agent in connection with these contracts, then my understanding was that [the payor] had to deal with NTSP and not with the individual physician himself.").

82. NTSP has advised health plans during rate negotiations for fee-for-service contracts and at other times that it represented NTSP member physicians, through power of attorney forms, (Roberts, Tr. 540-41), or otherwise (CX 760 (limited admission) (letters from NTSP physicians to Cigna

citing NTSP as their contracting "agent"); Beaty, Tr. 454-60).

3. Board minimums

83. "Board minimums" are the minimal acceptable rates for NTSP to enter into non-risk contracts with health plans. (Van Wagner, Tr. 1921; Frech, Tr. 1324). Payor offers falling below Board minimums are rejected by NTSP. (Frech, Tr. 1324. *E.g.*, F. 127, 154, 300, 341).

84. NTSP establishes Board minimum prices for use in negotiating non-risk contracts with health plans. (Van Wagner, Tr. 1642-43; Frech, Tr. 1321; *e.g.*, CX 274 (Fax Alert stating: NTSP "utilizes these minimums when negotiating managed care contracts on behalf of its participants.")).

85. Board minimums are also used by NTSP to predict when the participation rate of NTSP's member physicians will be high enough for NTSP to messenger an offer to its member physicians. (Deas, Tr. 2433; Maness, Tr. 2079-80). Multiple times over several years, NTSP has informed health plans that its physicians have established minimum fees for NTSP-payor agreements and that NTSP will not forward to its member physicians, or enter into a contract, based on payor offers that do not satisfy those fee minimums. (Van Wagner, Tr. 1822-24; CX 1196 (Van Wagner, 08.29.02 IHT at 63, 154)).

86. Board minimums may have been utilized as early as 1997. (CX 1042 (2001 Fax Alert from NTSP to its member physicians stating "NTSP board minimums have remained constant for four

years.")). NTSP conducted its first poll in either 1998 or 1999. (CX 1194 (Van Wagner, 11.19.03 Dep. at 86-87)).

87. NTSP conducts polls to determine minimum reimbursement rates for use in negotiation of non-risk contracts with health plans. (Van Wagner, Tr. 1639 ("We contact our physicians and we ask them to respond to a . . . survey on . . . what they believe are acceptable fees that they want to see in the nonrisk contracts."); CX 1196 (Van Wagner, 8.29.02 IHT at 27 ("Every year the Board asks the members to tell them what they consider to be appropriate reimbursement. . . . Once a year we poll the members and get that information from them.")); *e.g.*, CX 565).

88. NTSP's polling form explains to the member physicians that each year, "NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf of its participants." (CX 387 at 1; CX 633).

89. NTSP's polling form asks each physician to disclose the minimum price that he or she would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement. (CX 565; CX 1196 (Van Wagner, 08.29.02 IHT at 27)).

90. NTSP's member physicians are asked to indicate their price selection by placing a check mark next to one of several pre-printed Medicare RBRVS ranges. (CX 274; CX 565; CX 633).

91. By quoting a particular percentage of RBRVS, one can establish the prices for thousands of different services simultaneously. By using the Medicare index and a percentage of Medicare as a conversion factor, voluminous price information is reduced to a single dimension. (Frech, Tr. 1287).

92. NTSP's member physicians and physician groups do not consult with each other when responding to the poll. (Maness, Tr. 2049-50; Lonergan, Tr. 2718).

93. After receiving the poll responses, NTSP calculates the mean, median, and mode ("averages") of the minimum acceptable fees identified by its physicians and establishes its minimum contract prices. (Van Wagner, Tr. 1640; CX 103; CX 387).

94. NTSP informs its physicians of the average poll results and NTSP's minimum contract prices based thereon. (Van Wagner, Tr. 1644. *E.g.*, CX 393, CX 430, CX 1042).

95. NTSP physicians are informed only of the mean, median, and mode of the poll responses. They do not know how any other specific physician or physician group responded to the polls. (Van Wagner, Tr. 1641-44; Frech, Tr. 1436-37; Maness, Tr. 2044-46; Deas, Tr. 2423).

96. On October 15, 2001, the NTSP Board received annual poll results. Based on the poll results, NTSP established minimum prices of 125% of 2001 Medicare RBRVS for HMO products and 140% of 2001 Medicare RBRVS for PPO products as

minimally acceptable fee schedules for health plan contracts. (CX 103 at 4; CX 389).

97. On November 11, 2002, NTSP conducted another annual poll to determine minimum reimbursement rates for use in negotiation of HMO and PPO products and anesthesia contracts with health plans. On its polling form sent to physicians, NTSP included the prior year's poll results, reported by mean, median, and mode. (CX 430).

98. The results of the 2002 annual poll by mean, median, and mode, for HMO were 131%, 135%, and 135%; for PPO, 146%, 145%, and 145%. NTSP reported these figures to its member physicians and stated that the "poll's objective is to identify what reimbursement levels NTSP members deem acceptable." (CX 432).

99. By providing this pricing information to its member physicians, NTSP effectively informs the physicians of the potential reward for entering into a contract with health plans through NTSP, as opposed to entering into a contract with a health plan by directly negotiating with the health plan. (Frech, Tr. 1326).

100. Such price information sharing reduces each physician's uncertainty as to the conduct of its competitors in the aggregate. (Frech, Tr. 1327; *see also* CX 1170 (Blue, Dep. at 33) (poll results provide "a guideline where we saw the numbers, we would like to have these rates, if possible, and it kind of gave you an idea of where the market was. So if I got other communications independently and some . . . [were] paying 80 percent of Medicare, but it looked

like a lot of plans were paying 110 percent, then 80 percent of Medicare sounded pretty low.")).

E. NTSP's Dealings with Several Health Plans

1. United Healthcare Services, Inc.

a. Corporate structure

101. United Healthcare Services, Inc., is a wholly owned subsidiary of United Healthcare through which United Healthcare offers its PPO and other non-HMO products in Texas. (Quirk, Tr. 234-35, 239, 241, 247-48). United Healthcare of Texas is a wholly owned subsidiary of United Healthcare through which United Healthcare offers its HMO products in Texas. (Quirk, Tr. 235, 247-48). [United Healthcare Services and United Healthcare of Texas are collectively referred to as "United."]

102. United Healthcare is a subsidiary of United Health Group, a publicly traded company. (Quirk, Tr. 248; Wilensky, Tr. 2156). The success or failure of United's Texas entities are reflected in the stock price of United Healthcare. (Quirk, Tr. 248).

103. United contracts with multi-state employers, some of whom are domiciled outside of Texas but have employees in Texas, such as Raytheon and Home Depot. (Quirk, Tr. 253-54).

104. If health care costs rise in the Ft. Worth area, the pricing of the overall package to Raytheon or other national companies would be affected. (Quirk, Tr. 254-55).

105. Since 1999, Thomas J. Quirk has been the CEO for the North Texas and Oklahoma Region of United Healthcare Services, Inc., and the President, Chairman of the Board and the CEO of United Healthcare of Texas. (Quirk, Tr. 234-36).

106. Quirk oversees all of United's operations for the North Texas and Oklahoma regions, which include sales for commercial employers, municipalities and school districts; account management for United's existing customers and network operations, which encompass contracting with physicians, hospitals, and other provider networks; and maintenance of those relationships. (Quirk, Tr. 235-36).

b. NTSP's negotiations with United in 1998

107. In July 1998, NTSP informed its member physicians that United was attempting to standardize its physician agreements by, among other things, changing the fee schedule. (CX 1005 (Fax Alert #79)).

108. In Fax Alert #79, NTSP sent its physicians an agency agreement for the purpose of obtaining consent to enter into 'negotiations. NTSP stated that "[b]ecause United Healthcare has the potential to be a major payor in this market place, the NTSP Board wishes to contact them and negotiate on behalf of its membership." (CX 1005 at 2).

109. NTSP explained later that it was United's attempt to change fee schedules that

prompted NTSP negotiations with United. (CX 1014).

110. NTSP encouraged its member physicians to "refrain from responding to United Healthcare while NTSP's request for agency status [was] being tabulated." (CX 1005 at 2 (capitalization omitted)).

111. Some of NTSP's physicians authorized NTSP to negotiate with United on their behalf. (*E.g.*, CX 1006 (July 15, 1998 letter from Deas of Gastroenterology Associates of North Texas to Van Wagner allowing NTSP to serve as its agent in regard to future negotiations, including price terms, with United and instructing NTSP not to agree to any fee schedules lower than 135% of 1997 Medicare RBRVS for United's HMO product and 147% for United's PPO product); Deas, Tr. 2573-77).

112. On August 20, 1998, NTSP requested, and United granted, an extension on the time line for the assignment of contracts. (CX 1008). NTSP informed its member physicians of the extension and instructed them that they did not need to sign or return any documents or contracts to United. (CX 1008).

113. In September 1998, NTSP proposed to United that the Dallas Medicare RBRVS be used in calculating the rates for its HMO and PPO products for NTSP physicians, and informed its member physicians of this proposal in Fax Alert #94. (CX 1010).

114. NTSP also informed its member physicians in Fax Alert #94 that "[f]or many

specialists, Dallas rates are approximately three to five percent higher than PPO rates applied to Tarrant County." (CX 1010 at 2).

115. On October 27, 1998, in Fax Alert #101, NTSP informed its member physicians that discussions with United had been productive, that the parties agreed to extend the deadline, and that member physicians need not take any action with regard to standardizing their United contract until this extension expired. (CX 1011).

116. United made an offer to NTSP on a non-risk contract that was below the rates available to NTSP participating physicians through another IPA, Health Texas Provider Network ("HTPN"). (Van Wagner, Tr. 1726-27).

117. HTPN, which is an affiliate IPA of Baylor Health Care System, is an organization of employed as well as independent contracted physicians in Dallas. NTSP and HTPN had an arrangement whereby NTSP member physicians would be allowed to access HTPN's payor offers. NTSP did not participate in discussions with payors regarding economic terms of HTPN contracts. (Van Wagner, Tr. 1559-60; Quirk, Tr. 311-12; RX 1947).

118. On December 2, 1998, in Fax Alert #112, NTSP informed its member physicians that NTSP proposed to United that NTSP's physicians contract with United through HTPN. (CX 1012).

119. On March 9, 1999, in Fax Alert #12, NTSP recommended to its member physicians that they transition their existing contracts into a standard United contract, and assured them that

this would have no effect on the reimbursement rates that they were receiving under their current contract NTSP further informed its member physicians that "we [NTSP] continue our discussions with United Healthcare on proposed fee schedules for these products." (CX 1014).

120. Ultimately, a significant number of NTSP physicians accessed United through the NTSP-HTPN arrangement. (CX 1015).

c. NTSP's negotiations with United in 2001

121. Beginning in March 2001, NTSP member physicians contacted NTSP, asking that NTSP seek and obtain a contract with United. (CX 1117 at 1). On March 14, 2001, NTSP expressed to United its "desire for a group contract reflecting today's market." (CX 1117 at 2; Quirk, Tr. 284-89).

122. NTSP targeted United because NTSP believed that United's rates were below market rates. (CX 211 at 3 (NTSP informing its Primary Care Physician Council that they had identified United as a re-negotiating target, noting that United was becoming a significant player in the Fort Worth market and that United's rates were well below market)).

123. NTSP's discussions with United involved fee-for-service contracts. (Quirk, Tr. 291, 293-94).

124. As of March 2001, United had contracts with approximately two-thirds of the NTSP physicians, either directly or through other

125. On April 12, 2001, NTSP reported at its Primary Care Council Meeting that the reimbursement rates under the United-HTPN contract — 130% of 1997 St. Anthony RBRVS (145% Radiology) for HMO, 145% of 1997 St. Anthony RBRVS for POS, and 145% of 1997 St. Anthony RBRVS for PPO — were below market. (CX 209 at 3; CX 1015 at 4). A majority of NTSP physicians had accepted this contract in 1999 through NTSP's affiliation with HTPN. (CX 1015 at 1).

126. In or about May 2001, notwithstanding its view that United already had a sufficient network in Fort Worth, United offered to NTSP its then standard rates in the Fort Worth area: 110% of 2001 Dallas RBRVS, which was the equivalent of 115% of 2001 Tarrant County RBRVS, to NTSP. United's offer extended one rate for both HMO and PPO products. (CX 87 at 7; CX 89 at 3; Quirk, Tr. 290, 297-98).

127. NTSP did not messenger the May 2001 offer to its physicians and rejected it for two reasons: (1) it fell below NTSP's Board minimums; and (2) it extended one rate for all products, instead of different rates for HMO and PPO products. (Quirk, Tr. 300-01; CX 87 at 7).

128. On June 19, 2001, a United representative wrote to an NTSP representative, explaining that United's offered rates were identical for HMO and PPO reimbursement because, from the

129. On June 25, 2001, the NTSP Board discussed United's rate offer and rejected it. (CX 89 at 3; Quirk, Tr. 300-01).

d. NTSP's discussions with the City of Fort Worth

130. In 2001, NTSP physicians provided health care to the majority of employees of the City of Fort Worth and their dependents under NTSP's risk contract with PacifiCare. (Mosley, Tr. 148-49, 203).

131. The City of Fort Worth, in 2001, decided to become self-insured and began accepting bids from payors to become the administrator of its health plan. (Mosley, Tr. 148-49). One of the bidders against PacifiCare was United. (Mosley, Tr. 203-05; Van Wagner, Tr. 1743).

132. NTSP learned, in the spring of 2001, that United was negotiating with the City of Fort Worth to provide health care coverage to city employees and their dependents. (CX 89 at 3).

133. NTSP believed that United was threatening to displace an NTSP risk contract. . (Mosley, Tr. 206-07; Quirk, Tr. 363-65). If the City of Fort Worth selected United, the effect would be to remove this major employer's patients from NTSP's risk network (PacificCare) and substitute in its place a four-year-old non-risk contract that NTSP had with United through HTPN. (Van Wagner, Tr. 1728-29; CX 1042).

134. NTSP also had concerns about the adequacy of United's network and utilization management for the City's patient population and about United's ability to provide care to the City. (Van Wagner, Tr. 1729-35; Deas, Tr. 2424-25, 2429-30; Mosley, Tr. 185-87; Vance, Tr. 856-57; CX 1031).

135. During its negotiations with United, beginning in June 2001, NTSP encouraged its Board members to contact "any city council members they know to let them know that United's panel is not adequate." (CX 89 at 3).

136. NTSP also urged its primary care physicians to contact the Mayor and city council members to educate them about the situation with United and ask for help. (CX 211 at 3).

137. NTSP, on July 13, 2001, provided to its member physicians model letters for the purpose of contacting city officials. Attached to Fax Alert #44 was a sample letter to the Mayor of Fort Worth with the fax number for the Mayor and the names, addresses, fax numbers, and email addresses of the members of the city council. The sample letter included the following statements:

> Many of my patients are city employees or dependants and I/we have enjoyed caring for and managing their health for years. . .
>
> I look forward for your assistance in communicating to United that they offer a reasonable solution to this situation so I/we can continue to see

> City Employees and their dependants without disruption. . .
>
> In the best interest of my/our current City of Ft. Worth patients, I/we ask for your assistance in resolving this dispute before the City transitions to United Health Care.

(CX 1042 at 4).

138. On July 2, 2001, NTSP member physicians Blue, Vance, Deas, and Grant signed a letter addressed to the Mayor of Fort Worth bearing NTSP's letterhead. The letter asserted that United's rates were "well below market benchmarks" and that "NTSP simply has not and will not accept United's request for our participation in their provider network for your employees." The letter also asserted that "the City may experience significant network disruption once United officially begins their duties (up to 588 doctors no longer available)." (CX 1029 at 3-4; *see also* CX 1031 (July 9, 2001, letter from Vance to the Mayor of Fort Worth, stating that the City's recent switch to United placed the relationship between the City employees and their physicians "in serious jeopardy," that the United offer was "significantly below market," and stating that unless "this contractual issue is resolved," there was the "likelihood that NTSP members will no longer be available to city employees.")).

139. Other NTSP physicians wrote letters to the Mayor of Fort Worth reflecting the points discussed by NTSP in Fax Alert #44. (CX 1036; CX 1037; CX 1041; CX 1046).

140. NTSP, as an existing provider for the City of Fort Worth, arranged a meeting with the City and communicated to the City NTSP's concerns about the adequacy of United's panel and the cost impact on the City if the City were to change from the PacifiCare risk contract to the United non-risk contract. (Mosley, Tr. 186-87, 192-93; Van Wagner, Tr. 1744; Deas, Tr. 2424-25, 2429-31).

141. At the September 13, 2001 meeting with the City, NTSP representatives also told the City that United had offered rates on a non-risk contract with NTSP that were unacceptable to NTSP and that NTSP was going to reject the United offer. NTSP told the City that they may have a significantly different network on October 1, 2001, when the City would transition from PacifiCare to United. (Mosley, Tr. 186-87; CX 1042).

142. The NTSP Board informed its member physicians in Fax Alert #44, dated July 13, 2001, that NTSP Board members met with the Mayor of Fort Worth regarding the "possible inadequacy of the United network" and stated that although they "got the attention of the Mayor, our work is not done." (CX 1042).

143. Jim C. Mosley, a health care consultant to the City of Fort Worth, contacted a representative of United and shared with United the City's concerns regarding the continuation, maintenance, and preservation of the then existing United network. The possibility that City employees might lose access to NTSP physicians was a matter of concern to the City. United was requested to maintain the network without compromising costs. (Mosley, Tr. 173, 179-80, 182; Quirk, Tr. 309).

144. On September 13, 2001, NTSP met again with representatives of the City of Fort Worth. NTSP told the City that United's new, increased PPO reimbursement offer to NTSP physicians was still unacceptable. NTSP further expressed concerns about United's practice of "bundling" claims, pursuant to which physicians who provided multiple services on a single occasion were reimbursed at a single, bundled rate (lower than the rate at which each service would be compensated if billed separately). NTSP expressed its view that United's bundling practice under-compensated physicians. (Mosley, Tr. 185-93; CX 1075).

145. Following the September 13, 2001 meeting between NTSP and the City of Fort Worth, NTSP wrote a letter to the City of Fort Worth informing the City that United continued to offer low rates. (CX 1075 (Letter from Deas to City Manager for the City of Fort Worth, noting that despite some "positive movement," United's overall rates "may still prove inadequate" and this "may affect the overall size of United's physician network")).

146. NTSP's September 13, 2001 letter to the City of Fort Worth also reported that several physician's offices refused to contract with United unless a group contract through NTSP was negotiated on their behalf and noted that NTSP's termination notice to HTPN would take effect October 21, 2001. Notification letters to patients could be sent as soon as October 1, 2001, the same day as the City was supposed to transition to United. (CX 1075).

e. Continued negotiations and termination of HTPN contract

147. On July 9, 2001, NTSP informed United that United's current offer of 110% RBRVS (Dallas conversion factors) for all products was below the Board minimums that NTSP could accept. NTSP told United that the Board minimums were 125% RBRVS for HMO and 140% RBRVS for PPO (Tarrant County conversion factors). (CX 1034 at 1; Quirk, Tr. 299-01).

148. On July 13, 2001, in Fax Alert #44, the NTSP Board informed all NTSP member physicians that NTSP and United were in agreement as to basic fundamental language terms but "far apart in agreeing to a market reimbursement fee schedule." (CX 1042 at 1).

149. The NTSP Board also noted in Fax Alert #44 that many NTSP physicians were contracted with United through HTPN. The rates under the United-HTPN contract were indexed to 114% of 2001 Tarrant County RBRVS for HMO and 127% of 2001 Tarrant County RBRVS for PPO and were reported to be below or little above Medicare for many NTSP specialties. (CX 1042). The NTSP Board contrasted the NTSP minimums of 125% of 2001 Tarrant Medicare RBRVS for HMO and 140% of Tarrant Medicare RBRVS for PPO with United's direct offer to NTSP of 110% 2001 Dallas Medicare RBRVS for all products. (CX 1042).

150. The NTSP Board, in Fax Alert #44, also informed the member physicians that "the NTSP Board has authorized termination [of] the United

Health Care contract. However, notice has not yet been sent to United as NTSP must attempt one last strategy." (CX 1042).

151. On July 23, 2001, the NTSP Board approved the termination of its participation in the United-HTPN contract. (CX 91; CX 1051B). At that time, 101 of NTSP's physicians contracted with United through the United-HTPN contract. The rest of NTSP physicians contracted with United were through direct contracts (77) or through another IPA or other organizations. (CX 1055; CX 1057; Quirk, Tr. 302-04).

152. The effective date of termination was to be October 20, 2001, less than three weeks after the City of Fort Worth had planned to transition its employee health plans from PacifiCare to United. (CX 1051B; CX 1042 at 1).

153. On July 23, 2001 NTSP sent a letter to United, submitting its ninety day notice of its termination of participation in all United products offered through HTPN ("termination letter"). NTSP sent a copy of the July 23, 2001 termination letter to the Mayor of the City of Fort Worth. (CX 1118; Quirk, Tr. 312-13).

154. NTSP explained to its member physicians, by Fax Alert #52 dated August 9, 2001, that the United contract through HTPN was terminated because United offered rates below Board approved minimums and because of United's proposal of a single fee schedule for both HMO and PPO. (CX 1062).

f. Poll results used to establish Board minimums

155. United's May 2001 offer to NTSP of 110% of current Dallas Medicare RBRVS fee schedule fell below NTSP's Board minimums that had been determined by the Board based on the result of polling. (CX 1042).

156. Subsequent to the May 2001 offer, NTSP completed its annual reimbursement poll. As NTSP informed its member physicians, "[t]his poll's objective is to identify what reimbursement levels NTSP members deem acceptable." (CX 393).

157. On October 29, 2001, in Fax Alert #83, NTSP communicated to its member physicians the results of NTSP's annual reimbursement poll of NTSP member physicians' acceptable rates on both HMO and PPO levels. (CX 393).

158. The results of the 2001 annual poll for HMO were 128.46% (mean), 127% (median), and 127% (mode). The results for PPO were 142.07% (mean), 144.5% (median), and 144.5% (mode). "All percentages index to current Medicare rates and represent[] the percentage of Medicare that the 'average NTSP physician' would find acceptable for the next twelve months on HMO and PPO products." (CX 393).

159. On October 29, 2001, NTSP held a general membership meeting in which the offer from United was detailed along with the latest poll results which reflected a higher minimum for PPO than United's fee proposal. The PPO rate was listed as an "open issue." (CX 186 at 1).

g. Power of attorney forms

160. On August 9, 2001, in Fax Alert #52, NTSP solicited power of attorney forms from NTSP member physicians because, "[a]s with previous contracts, several members have requested that NTSP act on their behalf in regards to all contracting activity between themselves and United Health Care." (CX 1062).

161. The power of attorney provided to the physicians with Fax Alert #52 explained to them that "[t]his power of attorney grants to the agent the authority to act on the undersigned's behalf regarding the foregoing described agreements in all respects, including the authority to negotiate the terms of, enter into, execute, modify, extend or terminate any such agreements." (CX 1062 at 2-3).

162. A copy of Fax Alert #52 was obtained by United. Quirk made a handwritten notation on this copy indicating United's view that United needed to redevelop a network strategy for Tarrant County. (CX 1051; Quirk, Tr. 320-21).

163. United decided to try to recruit the terminated NTSP physicians directly. (CX 1056; CX 1057 at 1). In August 2001, shortly after receiving NTSP's termination letter, United made the decision that David Beaty, Senior Network Account Manager for United, would contact all of the affected NTSP physicians whose contracts with United through HTPN were to be terminated by NTSP. (Quirk, Tr. 334; Beaty, Tr. 452, 454).

164. Beaty wrote to these physicians, inviting them to continue participation in United's

network under a direct contract with United, and offered them the same reimbursement rates as they were receiving under the HTPN-United agreement. Some physicians accepted this offer. (Quirk, Tr. 334; Beaty, Tr. 452; CX 1068).

165. On August 24, 2001, in Fax Alert #56, NTSP informed its member physicians that NTSP had been receiving calls from some NTSP physicians regarding direct contract offers that they had received from United. NTSP reported that the rates paid to the NTSP physicians through the United-HTPN arrangement were below the NTSP acceptable Board minimums and noted that this had been NTSP's reason for terminating the HTPN arrangement. (CX 1066).

166. NTSP also informed its member physicians, in Fax Alert #56, that NTSP would "continue to pursue a direct contract with United Healthcare that meets or exceeds the fee schedule minimums set by the NTSP membership." (CX 1066).

167. Also, through Fax Alert #56, NTSP informed its member physicians that it had already received 107 executed power of attorney forms "from NTSP members assigning NTSP power of attorney to act on their behalf in regard to all contracting activity between themselves and United Healthcare," and sought the submission of executed powers by additional member physicians. (CX 1066 at 1-2; *see also* CX 1002 at 1-12).

168. NTSP advised those physicians who had signed the power of attorney forms that they "should inform all United representatives who

contact you that NTSP is your contracting agent for United Healthcare and instruct them to contact NTSP directly." (CX 1066 at 1; *see also* CX 1002 at 1-12).

169. United obtained a copy of Fax Alert #56 and learned that NTSP had gathered 107 power of attorney forms from physicians and that NTSP was continuing to solicit additional power of attorney forms to be used in collective bargaining with United. (Quirk, Tr. 326-27, 330-31; CX 1051A).

h. United offers increased rates

170. In the summer of 2001, United increased its offer to All Saints Integrated Affiliates ("ASIA"), another Fort Worth IPA through which 113 NTSP physicians had contracts with United. (CX 1055; Quirk Tr. 345; 336-37). United's offer to ASIA was 125% of 2001 Tarrant County RBRVS for HMO and 130% of Tarrant County RBRVS for PPO. (Quirk, Tr. 345). United made this offer to Medical Clinic of Northern Texas ("MCNT") also. (CX 1119 at 1).

171. In September 2001, United also extended the offer of 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO to the NTSP physicians whose contracts through HTPN had been terminated. (CX 658; *see also* CX 1119).

172. More than ten physicians' groups participating in NTSP did not respond to United's offer at this rate, even though it was higher than rates they had prior to their pending termination,

effective October 21, 2001, by NTSP. (Beaty, Tr. 454-55).

173. United's account representative contacted the physician groups that had rejected the new United offer. (Beaty, Tr. 454-55; CX 658; CX 1119). Some of those groups responded that they rejected United's offer for a direct contract because NTSP was negotiating on their behalf. (Beaty, Tr. 455, 459-60).

174. On September 5, 2001, NTSP held a general membership meeting, at which Van Wagner updated NTSP's member physicians on recent progress in contract negotiations with United. (CX 1076; CX 158).

175. On September 7, 2001, United declined NTSP's offer to attend an NTSP Board meeting. (CX 1121).

176. On September 13, 2001, in Fax Alert #60, NTSP reported to its member physicians that United had increased reimbursement levels "via a contract amendment with ASIA, as well as individual direct offers to several NTSP physicians." (CX 1076).

177. As a result of the increased offers, NTSP deferred activation of the power of attorney forms for two weeks, subject to NTSP's reconsideration. (CX 1076).

178. On September 19, 2001, NTSP informed its member physicians that in order to allow NTSP to consider the increased United offer available through ASIA or directly, NTSP would defer any

further action until September 27, 2001. NTSP would then contact each member who previously gave a power of attorney to determine if those member physicians desired additional action by NTSP on their behalf. Member physicians who considered individual contracts with United were invited to review the proposed negotiated group contract. (CX 1079).

179. In a September 20, 2001 letter, United accepted NTSP's invitation to meet with the NTSP Board. (CX 1080; Quirk, Tr. 338-39).

180. On September 21, 2001, Van Wagner updated NTSP's Medical Executive Committee on contract negotiations with United. (CX 198 at 2).

181. On September 24, 2001, United representatives met with NTSP's Board. NTSP stated that it opposed United's offer of one rate for all products because the offer was below Board minimums, which were different for HMO and PPO products. NTSP told United's representatives that PPO rates should be higher than HMO rates. (Quirk, Tr. 340-41, 344).

182. At the September 24, 2001 meeting, the NTSP Board also told United that NTSP's contractual arrangement with HTPN enabled NTSP to terminate the arrangement for United's products on behalf of its physicians. (CX 1081; Van Wagner, Tr. 1727-28).

183. In a September 24, 2001 letter, Deas invited United to reopen negotiations. (CX 1084).

184. On September 24, 2001, NTSP sent a letter to its member physicians with a summary of terms to be included in any direct contract with United. The summary discussed price related terms, including: (1) United's reimbursement methodologies should not translate into less than what Medicare would have paid; and (2) a fee maximum change from 80% of usual and customary to 100% of usual and customary. (CX 1064).

185. On or about October 10, 2001, United sent NTSP a new offer. United offered NTSP an increased rate of 125% of 2001 of Tarrant County RBRVS for HMO and 130% of Tarrant County RBRVS for PPO. (CX 1088; CX 1096; Quirk, Tr. 347-49).

186. NTSP and United signed a contract for 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO, effective November 1, 2001. (CX 1095 at 10).

187. The new contract represented an increase of 10% from the initial HMO offer and of 15% from the initial PPO offer. (Quirk, Tr. 290, 297-98). Compare CX 87 at 11 (for both HMO and PPO, 115% of Tarrant County RBRVS) *with* CX 1095 (for HMO, 125%; for PPO, 130% of 2001 Tarrant County RBRVS).

188. The contract was an increase from United's initial offer to NTSP. But, it was the same rate that United had previously offered other IPAs — ASIA and MCNT. (CX 1119). It was also a lower rate than the one given to HTPN in February 2001. (CX 1099).

189. On November 1, 2001, in Fax Alert #84, NTSP sent the contract to its member physicians to opt in or opt out, indicating that the contract was a result of negotiations and that the 125% of the 2001 Tarrant County RBRVS for the HMO was "at the average level of acceptable reimbursement." NTSP noted to its member physicians that the PPO rate of 130% of Tarrant County RBRVS was below the acceptable average reimbursement levels determined by the NTSP Board, based on the poll results. (CX 1097; Van Wagner, Tr. 1642-43).

190. Vance, a former NTSP President who at the time was a member of the NTSP Board of Directors, summarized NTSP's success in these United negotiations to his medical group, in an effort to convince the group to continue their membership with NTSP:

> United Health Care came to town six months ago and offered a straight 110% of Medicare contract. . . . Through the efforts of NTSP lobbying the City [of Fort Worth] and [terminating] a group contract with Health Texas, United blinked. United was so eager to dilute our effectiveness that they refused to negotiate with NTSP but offered an improved contract thru ASIA. The fees in the [ASIA] contract are very close to the numbers that NTSP presented as market rates for [Fort Worth] and were rejected out of hand by United officials. United has now returned to the table with NTSP at the direct

> request of the [C]ommissioner of the Dept[.] of Insurance. This United negotiation is a template for other efforts that will need to occur in the near future and would best be coordinated by NTSP.

(CX 256; *see also* CX 1199 (Vance, Dep. at 310-11)).

191. The level of acceptance of the NTSP/United contract by NTSP member physicians was low. (CX 1100). Fax Alert #95, dated November 19, 2001, indicates that 258 NTSP member physicians responded. (CX 1100). For HMO, 24% accepted and 76% rejected the contract. For PPO, 23% accepted and 77% rejected the contracts. (CX 1001 at 2).

i. NTSP reported United to Texas Department of Insurance

192. NTSP reported United to the Texas Department of Insurance in 2000 and 2001 for prompt pay violations, noncompliance with contracts, and predatory pricing concerns. (Van Wagner, Tr. 1772).

193. NTSP's Board Minutes of September 24, 2001, reported that Deas met with the Texas Commissioner of Insurance to discuss predatory pricing by health plans. The Commissioner stated that he would send letters to CEOs of major plans cautioning them against predatory pricing activities. Deas also discussed with the Commissioner the impact of HMO and PPO contracting revisions on Tarrant County physicians. (CX 100 at 3-4).

194. In August 2001, the Texas Department of Insurance fined United $1.25 million and ordered it to pay restitution to providers for failing to follow Texas laws on prompt payment and clean claims. (RX 3103).

2. Cigna Healthcare

a. Corporate structure

195. Cigna of Texas is a subsidiary of Cigna Healthcare ("Cigna") which has its corporate headquarters in Philadelphia, Pennsylvania. (Grizzle, Tr. 669). Cigna Corporation reports consolidated earnings for the entire corporation, including Cigna of Texas. (Grizzle, Tr. 669-70).

196. A change in revenue and earnings for Cigna of Texas would affect the revenues and earnings for the entire corporation. (Grizzle, Tr. 670).

197. When Cigna contracts with multi-state employers, a single contract is signed. (Grizzle, Tr. 682). A change in costs for Cigna of Texas could affect the health insurance costs of an employer with multi-state coverage. (Grizzle, Tr. 683).

198. An increase in Cigna's costs would increase premiums which could affect Cigna's competitiveness in other states. (Grizzle, Tr. 683-85).

199. Mr. Rick Grizzle is the vice president of network development for Cigna Healthcare, with responsibilities for contracting and managing

provider services in Texas, Oklahoma, and Louisiana. (Grizzle, Tr. 666-67).

b. Cigna's acquisition of Healthsource and initial contacts with NTSP

200. In late 1997, Cigna purchased Healthsource, a company which offered both HMO and PPO products, covering approximately one million lives nationally. Many NTSP member physicians had direct contracts with Healthsource. (Grizzle, Tr. 695, 767-70).

201. For physicians with agreements with both Cigna and Healthsource, Cigna, in July 1998, informed physicians that their contracts under Healthsource would be terminated and assigned to Cigna. (CX 332; Van Wagner, Tr. 1752-53).

202. For physicians with agreements with only Healthsource, Cigna, in July 1998, requested that physicians assign their contracts from Healthsource to Cigna and informed physicians that if they did not wish to assign their contracts to Cigna, they could continue under their Healthsource agreements, as long as Healthsource products were being offered in the marketplace. (CX 332; Van Wagner, Tr. 1752-53).

203. Healthsource subsequently went out of business. (Grizzle, Tr. 770).

204. Some NTSP physicians went to NTSP regarding the change in their Healthsource contracts and requested that NTSP contact Cigna. (Van

Wagner, Tr. 1752). NTSP did contact Cigna regarding these issues. (Van Wagner, Tr. 1753-54).

205. NTSP sent to its member physicians a sample letter refusing the contract assignment from Healthsource to Cigna and directing Cigna to negotiate with NTSP as their agent. NTSP also sent its member physicians an agency agreement that authorized NTSP to negotiate on the behalf of consenting member physicians. NTSP informed its physicians that "if 50% or more of NTSP member physicians concur that agency is appropriate, NTSP will contact CIGNA and Healthsource directly in regards to this matter." NTSP advised "its members not to consent to the assignment of your Healthsource provider agreements to CIGNA." (CX 332 (*emphasis omitted*)).

206. Cigna received 40 letters, all virtually identical to the sample letter provided by NTSP, representing 52 NTSP member physicians, in which NTSP physicians did not agree to assign to Cigna their Healthsource agreements, and which directed Cigna to negotiate with NTSP on their behalf. (CX 760 (limited admission); Grizzle, Tr. 696-98, 709, 724).

207. The physicians who did not agree to assign their Healthsource agreement to Cigna believed that they had the right to do so. (Van Wagner, Tr. 1753-54; Grizzle, Tr. 768).

208. Upon receiving these letters, Cigna concluded that the 52 physicians who had sent Cigna letters would not directly contract with Cigna and that Cigna would need to approach NTSP instead. (Grizzle, Tr. 697, 709-10, 747).

209. Cigna has entered into direct contracts with some NTSP physicians independent of NTSP. (Grizzle, Tr. 724). In some instances, the direct contract between Cigna and physician is at a higher reimbursement rate than the Cigna/NTSP contract. (Deas, Tr. 2410).

c. NTSP's negotiations with Cigna

210. Beginning in 1999, NTSP sought a risk contract with Cigna. (Grizzle, Tr. 775; Van Wagner, Tr. 1754-55; CX 764, *in camera*). NTSP and Cigna were unable to agree to a risk-sharing arrangement. (Van Wagner, Tr. 1758; CX 764, *in camera*).

211. Cigna and NTSP have entered into several fee-for-service agreements. These agreements are: the Letter of Agreement, the First Amendment, the Second Amendment, and the Third Amendment. (CX 764, *in camera*; CX 769; CX 771 at 1, *in camera*; CX 809, *in camera*; CX 810, *in camera*; Grizzle, Tr. 715-16; Grizzle, Tr. 723-24).

(i) Letter of Agreement, First Amendment

212. NTSP and Cigna entered into a Letter of Agreement (LOA) in October of 1999. The LOA only covered fee-for-service rates for Cigna's HMO business, and not its PPO business. (Grizzle; Tr. 710-11; CX 782A, *in camera*).

213. Under the LOA, Cigna agreed to reimburse NTSP specialists, with the exception of cardiologists/cardiovascular surgeons,

gastroenterologists, urologists, oncologists, and podiatrists, on a fee schedule equal to 125% of the 1998 Dallas County RBRVS. (Grizzle, Tr. 710-14; CX 782A, *in camera*; CX 764 at 1, *in camera*).

214. Cigna entered into this agreement with NTSP because Cigna believed that the core group of NTSP, the specialists in Fort Worth, were critical for Cigna. (Grizzle, Tr. 719-20).

215. The LOA was entered into by NTSP and Cigna in anticipation of a risk contract and specifically called for the establishment of a risk contract within a short time. (Van Wagner, Tr. 1757-58; CX 784, *in camera*; CX 782A, *in camera*).

216. The 1999 LOA was amended in January 2000 (First Amendment) to add PPO coverage for NTSP specialists at a reimbursement rate of 135% of Dallas County 1998 RBRVS. (CX 769; Grizzle, Tr. 714).

217. Cigna's representative, Grizzle, testified that the reimbursement rate of 125% of RBRVS on HMO and 130% of RBRVS on PPO was somewhere between 15 and 20 percent higher than Cigna's standard rates. Grizzle also testified that the rates Cigna paid to NTSP were in the "general ballpark" of the rates Cigna paid to other IPAs { }. (Grizzle, Tr. 716, 958-59, *in camera*).

(ii) Conflicts between NTSP and Cigna

218. NTSP believed that Cigna had breached its contract with respect to how fee schedules were loaded into Cigna's system. There were instances of

a change in the fee schedule as called for by the contract where NTSP would later find that Cigna had failed to load the changes. NTSP complained to Cigna regarding Cigna's failure to pay in accordance with the agreed upon schedule and informed Cigna that NTSP considered the failure a material breach. (Grizzle, Tr. 797; Van Wagner, Tr. 1769; CX 792, *in camera*; RX 497; RX 960, *in camera*; RX 1486, *in camera*).

(iii) Second Amendment

219. NTSP also believed that Cigna breached the LOA and First Amendment by not adjusting the fee schedule to current year RBRVS. (Grizzle, Tr. 799-800; Van Wagner, Tr. 1979-80).

220. The 1999 LOA was amended in May 2000 (Second Amendment) to clarify the proper year of RBRVS reimbursement. While the First Amendment to the LOA did not require that the fee schedule be adjusted annually, the Second Amendment explicitly called for an annual adjustment of the HMO and PPO schedule to current year { } RBRVS. (CX 769; CX 770, *in camera*; CX 771, *in camera*; CX 800 at 2; Grizzle, Tr. 715, 740-41).

(iv) Cardiologists

221. Under the LOA, Cigna agreed to reimbursement of "NTSP specialists, with the exception of NTSP cardiologists/CV [cardiovascular] surgeons, gastroenterologists, urologists, oncologists and podiatrists." (Grizzle, Tr. 710-14; CX 782A, *in camera*).

222. NTSP's cardiologists were carved out of the LOA. (Grizzle, Tr. 927, *in camera*; Van Wagner, Tr. 1764-66).

223. In a carve out arrangement, certain specialists or services are outside of a capitation plan and are paid in some other manner. (Frech, Tr. 1434).

224. Although NTSP's cardiologists were initially carved out of the LOA, an addendum to the LOA gave a right of first refusal for NTSP's cardiologists to participate with Cigna if Cigna's carve out agreements with cardiologists were terminated. (Grizzle, Tr. 927, *in camera*; Van Wagner, Tr. 1764-66; CX 770, *in camera*).

225. Regarding Cigna's need for cardiologists, Cigna had contracted with American Physician Network ("APN") for cardiology services. (Grizzle, Tr. 726-27, 929-30, *in camera*).

226. In July 2000, Cigna informed NTSP that the carve out arrangement that Cigna had with NTSP had been assigned to APN and told NTSP to work out an agreement with APN. (Grizzle, Tr. 929-30, *in camera*; Van Wagner, Tr. 1768; CX 775).

227. Cigna viewed its action as an assignment of the contract and believed that the LOA did not allow NTSP's cardiologists to join the Cigna fee-for-service contract if the carve out had been assigned. (Grizzle, Tr. 725).

228. NTSP viewed Cigna's action as Cigna's termination of the cardiologists' carve out agreement. NTSP believed that Cigna had breached

the LOA by refusing to give NTSP's cardiologists a right of first refusal to participate in the NTSP agreement. (Grizzle, Tr. 929-30, *in camera*; Van Wagner, Tr. 1766-68; CX 775; CX 776; CX 784; CX 785, *in camera*).

229. NTSP sent Cigna a letter, dated August 2, 2000, stating that NTSP was exercising its option under the terms of the present Cigna arrangement for NTSP cardiologists to participate under the terms of the HMO arrangement. (CX 776).

230. APN subsequently submitted a fee-for-service offer to NTSP's cardiologists. (Grizzle, Tr. 726-27).

231. NTSP rejected APN's offer, in a letter dated October 6, 2000, which stated that the offer "was shared with affected members of NTSP's Cardiology Division and NTSP's board. At this point, we must decline your proposal as it does not meet our minimum reimbursement levels." (CX 777A; Grizzle, Tr. 726-27).

232. In an October 16, 2000 letter from NTSP to Cigna, NTSP stated that NTSP's Cardiology Division and Board found Cigna's proposal to be "woefully inadequate. The financial arrangements proposed were well below the agreed upon fee schedule contained in the NTSP/Cigna agreement. As a result, [APN] was notified on October 6, 2000 that [their] proposal was declined, as it did not meet minimum reimbursement levels." (CX 777).

233. The October 16, 2000 letter from NTSP to Cigna also states that "[o]bviously Cigna's failure

to resolve this issue may affect current NTSP participation and future dialogue with Cigna regarding a PSN [provider sponsored network] type risk arrangement." (CX 777; Grizzle, Tr. 730).

234. NTSP believed that it had the right to terminate its contract with Cigna if what NTSP believed to be Cigna's breaches of contract were not cured. (Grizzle, Tr. 797; Van Wagner, Tr. 1769-71; RX 497; RX 960, *in camera*; RX 1486, *in camera*).

235. Cigna performed an analysis of the impact of the potential loss of NTSP's physicians from its network. Cigna determined that NTSP's termination would leave it with gaps in specialty coverage in the Fort Worth area. (Grizzle Tr. 730-31 (stating that Cigna took the threat seriously because NTSP presents "a fairly unified force, well-represented and looked like a strong entity . . . working in Fort Worth"); CX 779, *in camera* (charting impact of NTSP termination by specialty)).

236. Within the next twelve months, APN went bankrupt and dissolved. Cigna then allowed NTSP's cardiologists to participate in the Cigna/NTSP agreement. (Grizzle, Tr. 731-32, 937 (*in camera*); Van Wagner, Tr. 1768).

(v) Third Amendment: primary care physicians

237. Under the 1999 contract between Cigna and NTSP, Cigna agreed to reimburse "NTSP specialists," with the exception of those specialists explicitly carved out. (Grizzle, Tr. 710-14; CX 782A, *in camera*).

238. NTSP sought to have its primary care physicians ("PCPs") included under its contract with Cigna. By letter dated November 9, 2000, NTSP wrote to Cigna expressing its belief that the agreement between Cigna and NTSP was in serious jeopardy due to Cigna's refusal to allow NTSP cardiologists to participate at the contracted rate. NTSP wrote: "in an effort to maintain NTSP network participation during this critical period of open enrollment, I believe a timely good faith gesture by Cigna would be appropriate." One of the terms which NTSP would consider was that, "Cigna immediately allow all of NTSP's sub-contracted Primary Care Physicians the option to participate under the terms of our HMO and PPO agreements." (CX 786, *in camera*; Grizzle, Tr. 732).

239. Cigna had already contracted with a sufficient number of primary care physicians at lower rates than those under the NTSP agreement. Allowing NTSP's primary care physicians to opt in to the NTSP/Cigna specialist contract would increase Cigna's costs with no additional benefit to Cigna. (Grizzle, Tr. 718-19, 733-34).

240. In order to maintain the relationship with NTSP and despite increasing its costs, Cigna offered NTSP's primary care physicians a tiered reimbursement fee schedule in which the primary care physicians would initially receive NTSP's specialist rates and would, over time, return back to a "market level." (Grizzle Tr. 735-36).

241. In December 2000, NTSP rejected Cigna's offer on behalf of its primary care physicians. (Grizzle, Tr. 736; CX 791 ("NTSP's Board absolutely cannot and will not negotiate or offer an agreement

in which our PCP partners are paid less than our specialists . . . . The 125% of the then current Dallas (not Tarrant County) RBRVS must stand as per our current agreement.")).

242. On June 7, 2001, NTSP sent an email to Cigna requesting that Cigna bring NTSP primary care physicians into the NTSP/Cigna agreement on the PPO product. (CX 800 at 1).

243. By return email that same day, June 7, 2001, Cigna reiterated its resistance to NTSP's demands to include NTSP's primary care physicians at NTSP's specialist rates. (CX 800 at 2; Grizzle, Tr. 740-41).

244. NTSP subsequently, on June 12, 2001, sent a notice of termination letter to Cigna, providing Cigna with 60 days notice. NTSP's letter stated, NTSP "look[s] forward to utilizing the next 60 days in resolving the issue of Cigna not allowing our affiliated Primary Care Physicians to participate under the terms of our PPO agreement." (CX 802).

245. In response to NTSP's notice of termination letter, Cigna and NTSP negotiated a third amendment to the NTSP/Cigna contract. (Grizzle, Tr. 749-51; Van Wagner, Tr. 1771; CX 810, *in camera*).

246. The 1999 LOA was amended in August 2001 (Third Amendment) { } (Grizzle, Tr. 749-51, 755, 942-43, *in camera*; Van Wagner, Tr. 1771-72; CX 809, *in camera*; CX 810, *in camera*).

247. The Third Amendment is the current contract under which Cigna and NTSP were

operating at the time of trial (April 2004), and was set to expire September 14, 2004. (CX 809, *in camera*; CX 810, *in camera*).

248. Cigna estimated that it would cost Cigna { } to add more NTSP physicians to the NTSP/Cigna arrangement. These additional physicians were already individually-contracted with Cigna at "market rates." (CX 814, *in camera*). Cigna realized no benefit from having these additional NTSP physicians in the network. (Grizzle, Tr. 877-79, *in camera*).

(vi) Third Amendment: terms

249. The contract between NTSP and Cigna that was current at the time of trial, April 2004, the Third Amendment, is a non-risk agreement. (CX 809, *in camera*; CX 810, *in camera*; F. 251-55).

250. Under the Third Amendment, PPO reimbursement is at a rate of{ } and HMO reimbursement is at a rate of ( ). (CX 809, *in camera*; CX 810, *in camera*).

251. In NTSP's summary of the contract terms, NTSP characterizes the agreement as a "non-risk agreement." (CX 810, *in camera*).

252. The Third Amendment does include: capitation payments, a pay-for-performance provision, and a withhold provision. (Van Wagner, Tr. 1758-59, 1761; F. 253-55).

253. { } (Grizzle, Tr. 755, 879-80, *in camera*).

254. { } (Grizzle, Tr. 880, 896, 946-48, *in camera*; Van Wagner, Tr. 1974-76).

255. { } (Grizzle, Tr. 881-82, *in camera*).

d. NTSP reported Cigna to Texas Department of Insurance

256. NTSP reported Cigna in 2000 and 2001 to the Texas Department of Insurance for prompt pay violations, noncompliance with contracts, and predatory pricing concerns. (Van Wagner, Tr. 1772).

257. In August 2001, the Texas Department of Insurance took action against Cigna for violations of Texas claims payment laws. Cigna was fined $1.25 million and ordered to pay restitution to providers as a result of Cigna's failure to comply with clean claims laws. (RX 3103).

258. In September 2001, the Texas Attorney General investigated Cigna's payment methodology. (CX 108 (Board minutes reporting Office of Attorney General's letter); RX 1290; RX 1651).

3. Aetna Health, Inc.

a. Corporate structure

259. Aetna Health, Inc., ("Aetna") is a wholly owned subsidiary of Aetna, Inc., which has its headquarters in Hartford, Connecticut. (Roberts, Tr. 474).

260. Aetna provides health insurance coverage in the North Texas area. In the Fort Worth

261. Aetna's network has about 7,200 physicians in the Dallas-Fort Worth Metroplex. (Jagmin, Tr. 1121).

262. Aetna's clients in the Fort Worth area include national companies such as Bell Helicopter and Lockheed Martin. (Roberts, Tr. 476).

263. When Aetna pays a claim in Texas, it is paid from premiums which may have come from states outside of Texas. (Roberts, Tr. 476).

264. Aetna's performance in the Fort Worth area affects Aetna's national performance because any profits or losses roll up and appear on the financial statements of the publicly traded parent company. (Roberts, Tr. 474, 477).

265. Dr. Christopher Jagmin is currently the medical director for medical policy. (Jagmin, Tr. 969). Jagmin works for Aetna, Inc., based out of Blue Bell, Pennsylvania, and he consults and advises for the North Texas area. (Jagmin, Tr. 972, 974).

266. Mr. David Roberts is employed by Aetna Health, Inc., as a network vice-president. He has worked for Aetna Health, Inc., (or another subsidiary of the national company) since 1999, when Aetna acquired Prudential. Prior to 1999, Roberts worked for Prudential. In May 2001, Roberts assumed responsibility for contracting with physicians in the North Texas area. (Roberts, Tr. 468-70).

b. NTSP's relations with Aetna through HMS and MSM

267. In 1994, many physicians signed an HMO risk contract and a PPO non-risk contract to treat Aetna patients through another IPA, Harris Methodist Select ("HMS"). (Van Wagner, Tr. 1692; RX 832).

268. The 1994 HMS contracts with Aetna were exclusive and were not terminable until June 30, 1999. (RX 3146).

269. Many of the physicians who had contracts with HMS signed participating physician agreements with NTSP. (RX 832).

270. In 1997, NTSP believed that HMS had breached the 1994 contracts by attempting to amend those contracts without consent, agreeing to non-exclusivity with Aetna, and failing to make full payments to physicians. (Vance, Tr. 591; Van Wagner, Tr. 1692; RX 309; RX 310; RX 832).

271. NTSP was appointed by NTSP's participating physicians to represent them in the contract dispute with HMS. (Van Wagner, Tr. 1681).

272. In 1999, during the time of the contract dispute between NTSP and HMS, HMS became Medical Select Management ("MSM"). Contracts between physicians and HMS were assigned to MSM. (RX 832).

273. The contract between MSM and Aetna, which served about 115,000 patients, was primarily

a "global risk deal," through which Aetna delegated almost all the medical risk to MSM under an HMO plan. (Jagmin, Tr. 984-85, 997). MSM also had a non-risk PPO contract with Aetna. (RX 832).

274. Many of NTSP's participating physicians had been contracted with MSM to provide physician services pursuant to MSM's agreements with Aetna. (Jagmin, Tr. 982).

275. In June 1999, NTSP, as the class representative for its participating physicians, sued HMS and MSM. The class action lawsuit against HMS and MSM alleged that HMS and MSM refused to honor the terms of the 1994 contract. (Van Wagner, Tr. 1652-53; RX 335; RX 849; CX 1172 (Collins, Dep. at 6-9)).

c. NTSP's initial contract negotiations

276. In late 1999, NTSP initiated a meeting with Aetna and proposed a direct contracting relationship between Aetna and NTSP, that would not involve MSM, under a risk contract. (Jagmin, Tr. 981-84; Van Wagner, Tr. 1700; CX 531). This meeting did not develop into broader negotiations. (Jagmin, Tr. 988-89).

277. Around April 2000, NTSP again initiated negotiations with Aetna to discuss a direct contract between NTSP and Aetna. (Jagmin, Tr. 989-90).

278. In early June 2000, NTSP met with Aetna to discuss future business and contract arrangements. (CX 177). NTSP told Aetna that its

physicians might leave the MSM contract because of what NTSP perceived to be MSM's continuing breaches of contract and financial problems. (Jagmin, Tr. 983-84; Van Wagner, Tr. 1652-53, 1692-95, 1700; CX 531).

279. Subsequent to the June 2000 meeting between NTSP and Aetna, Aetna discussed internally the possible contracting scenarios with NTSP and concluded that the most favorable scenario was keeping NTSP's physicians within Aetna's current contract through MSM, rather than signing a separate contract with NTSP. This conclusion was based on Aetna's belief that a separate contract would duplicate administrative costs. (CX 525 at 1-2).

280. The internal Aetna discussion considered a scenario in which Aetna would lose most of NTSP's member physicians. This turn of events was envisioned by Aetna as a realistic possibility if NTSP's member physicians were to pull out of the MSM contract, Aetna were to fail to reach an agreement with NTSP, and only a few of NTSP's member physicians were to contract with Aetna directly. Aetna's conclusion was that this scenario would create undesirable holes in particular specialities and perhaps service areas. Under the same scenario, Aetna was also "very concerned" with the fact that many of its health plan members, especially "given their national client base," would complain that their doctor was no longer in the network. (CX 525; Jagmin, Tr. 1000-02).

281. In these internal Aetna discussions, NTSP was perceived as representing the "majority of

the preferred SPECs [specialists] in [Fort] Worth," and as specialist-dominated. (CX 525 at 2).

282. In Fax Alert #55, dated August 7, 2000, Van Wagner informed NTSP member physicians that "NTSP has started negotiations with Aetna in regards to a risk and non-risk contract. As of this date, a term sheet has been received and is being reviewed. It is the goal of both parties to implement a new contract effective January 1, 2001. Given the stages of our negotiation, NTSP will know in approximately thirty days whether or not a direct contract with Aetna will be in the best interest of its members." NTSP asked its member physicians to allow NTSP to continue discussions with Aetna for the next thirty days. (CX 942 at 2).

283. An October 5, 2000 Fax Alert informed NTSP physicians that NTSP had filed suit against MSM on behalf of its member physicians and that NTSP had begun discussions with Aetna on a direct contract for Aetna HMO patients. The Fax Alert sought physicians to sign a power of attorney to authorize NTSP to represent them:

> In order to pursue these initiatives to their maximum outcome, having NTSP act as the members' agent and attorney in fact in negotiations, amendments, extensions and/or terminations of Aetna contracts was suggested.
>
> A Motion was made and passed that 66% of all affected NTSP physicians should agree to NTSP's role as agent

> or attorney in fact regarding this matter.
>
> Attached to this fax is a copy of a Power of Attorney for each member's consideration. If you wish NTSP to represent you as your attorney in fact regarding your contracts with Aetna US HealthCare, . . . please sign below and fax return to the NTSP offices. . . .

(CX 347 at 1-2).

284. The power of attorney appointed NTSP to act as the signatory attorney in fact with respect to "all contracts and agreements (including without limitation all prospective contracts or agreements)" with Aetna, MSM, and other entities. (CX 347 at 4).

285. In October 2000, negotiations between NTSP and Aetna for a risk contract ended without an agreement. (Jagmin, Tr. 1006-09; CX 540 at 1).

d. Continued negotiations on a non-risk contract

(i) Initial proposals

286. In October 2000, after NTSP and Aetna determined that they could not agree on a risk contract, NTSP and Aetna continued to negotiate for a non-risk contract only. (Jagmin, Tr. 1004-05; CX 717 at 4; CX 544 at 3).

287. With respect to rates for anesthesiologists, Aetna's initial offer to NTSP, in October 2000, was $40 per unit. NTSP told Aetna

that anesthesia unit rates for a PPO product were between $46 and $48 in the market. (Jagmin, Tr. 1017, 1034-35, 1045; CX 544 at 2, 3). In an October 20, 2000 letter, Aetna informed NTSP that an anesthesia rate of $46 to $48 was too high. (CX 540 at 4; Jagmin, Tr. 1017).

288. With respect to HMO and PPO products, Aetna's initial offer to NTSP, in October 2000, was based on a reference schedule that uses the same relative value units from the RBRVS schedule, but places a different multiplier on different specialties' services, based on supply and demand. (Jagmin, Tr. 1012-13). Aetna's initial offer aggregated to about 111% to 112% RBRVS for HMO and about 123% to 125% RBRVS for PPO, with some specialities being offered more or less than the aggregate, based on the scarcity or abundance of the particular specialty of the physician. (Jagmin, Tr. 1015-16, 1022-24).

289. In October 2000, NTSP sought from Aetna a non-risk contract with uniform rates of 125% RBRVS for HMO and 140% RBRVS for PPO. (Jagmin, Tr. 1023, 1033-34, 1040-41; CX 543 at 3-4).

290. NTSP's proposed rates of 125% of RBRVS for HMO and 140% of RBRVS for PPO were the same rates that physicians had been receiving for providing services to Aetna patients through the MSM contract. (Jagmin, Tr. 1023; Van Wagner, Tr. 1697; CX 538). (*Compare* RX 968, *in camera*, with RX 24 at 21).

291. NTSP's proposal for both HMO and PPO was a uniform rate for all physicians, instead of the different rates to each speciality that Aetna

initially had offered. (CX 543 at 3-4; Jagmin, Tr. 1023).

292. Aetna expressed concern to NTSP that a uniform rate based off of Medicare RBRVS would impose overpayment to some NTSP specialties, while other NTSP physicians might choose not to participate on the basis of underpayment, which might require Aetna to have to contract with those physicians individually at a higher rate. (Jagmin, Tr. 1031-32).

293. NTSP informed Aetna that it would not be involved in any non-risk contract that proposed different rates for different member physicians. (Roberts, Tr. 523-24; Jagmin, Tr. 1165).

294. Aetna's representative talked to physician groups to try to contract with them directly. Some of those physicians referred Aetna back to NTSP. (Jagmin, Tr. 1042-44).

295. Aetna, at the time of these negotiations, was concerned about losing physicians because it was late in the enrollment period, the time when employees choose their health plans or change their prior selections. (Jagmin, Tr. 990-91; 1060-61).

296. On November 7, 2000, NTSP sent a letter to "NTSP Members," providing them with a termination letter that NTSP's Board of Directors "is sending to . . . MSM on your behalf. . . . This termination letter notifies MSM that they are in material breach of your 1994 contract regarding the Aetna HMO." (CX 546).

297. On November 20, 2000, NTSP sent Aetna an email informing Aetna that NTSP physicians would no longer serve Aetna's patients through MSM:

> North Texas Specialty Physicians' (NTSP) 260 doctors have treated Aetna patients for over ten years. . . . We are pleased that Aetna has contacted us in an effort to work out the details for a direct contracting relationship. . . . If a direct contracting relationship between NTSP and Aetna is accomplished, all of Aetna's PPO lives will be served directly by NTSP physicians. In addition, approximately 15,000 of the 100,000 Aetna HMO covered lives will have direct access to NTSP doctors. The remaining approximately 85,000 Aetna HMO covered citizens are contracted through Medical Select Management's Aetna contract.
>
> As of today, NTSP has notified Medical Select Management that under current contractual conditions, NTSP physicians can no longer participate.

(CX 559).

298. By November 20, 2000, Aetna made a new offer of a uniform rate based on RBRVS and increased its offer to 116% RBRVS for HMO and 140% for PPO. Aetna's offer on anesthesia rates

remained at $40 per unit. (CX 561; Jagmin, Tr. 1044-45, 1076-77).

299. With respect to Aetna's PPO and anesthesia offer, Van Wagner informed Aetna that she thought that Aetna's PPO fee schedule of 140% of current Medicare RBRVS would be "well received when we messenger it out by all except anesthesia. . . . [A]s you know their contracting minimums on PPO rates were not met." Jagmin understood that most member physicians would accept the 140% rate for PPO, but that no anesthesiologist would sign up under the contract. (CX 558 at 2; Jagmin, Tr. 1052).

300. With respect to Aetna's HMO offer, NTSP did not present Aetna's HMO offer to its member physicians because the rate fell below the established Board minimums. (Van Wagner, Tr. 1927-28).

301. Aetna's representative met with NTSP's Board and had conversations with Board members and with Van Wagner and NTSP's Director of Managed Care, David Palmisano, in which both physicians and NTSP staff conveyed to Aetna that NTSP's Board minimum was 125% of RBRVS for HMO and that NTSP did not have the authority to messenger any contracts below these rates. (Jagmin, Tr. 1021-23; CX 571).

(ii) Power of attorney forms

302. At the same time that NTSP and Aetna were discussing the non-risk contract, Van Wagner sent Aetna a list of the physicians to whom NTSP had sent power of attorney forms seeking delegation

of NTSP as the organization that would conduct negotiations for them. (Jagmin, Tr. 1029; CX 534).

303. Jagmin asked both physicians and NTSP staff about the power of attorney forms and was told that the power of attorney forms assigned to NTSP direct contracting efforts between Aetna and the physicians. (Jagmin, Tr. 1029).

304. On November 10, 2000, Van Wagner informed Jagmin that NTSP had sent approximately 180 power of attorney forms from NTSP member physicians to MSM, and told Jagmin that the powers of attorney cover any direct contracting with Aetna. (CX 558 at 2).

305. Aetna believed that, with these power of attorney forms, NTSP would be representing individual physicians in negotiating with Aetna if Aetna did not enter into a contract with NTSP. (Jagmin, Tr. 1051; CX 558).

306. Because Aetna believed that NTSP was going to represent each one of the individual physicians or physician groups in a direct contract negotiation, Aetna believed that there was pressure for Aetna to enter into a contract with NTSP. (Jagmin, Tr. 1058-60).

307. In a November 2001 NTSP Board meeting that was attended by an Aetna representative, the power of attorney forms that NTSP had collected from its member physicians were referenced during the discussions between NTSP and Aetna on the proposed rates for a non-risk contract. (Roberts, Tr. 537-39).

(iii) Re-polling of NTSP member physicians

308. By November 21, 2000, Aetna and NTSP had reached an agreement on 140% of current Medicare RBRVS for PPO, but had not reached an agreement on HMO rates, with NTSP seeking across the board 125% of Medicare RBRVS and Aetna seeking across the board 116% of Medicare RBRVS. The parties also had not reached an agreement on anesthesia rates. (CX 561; Jagmin, Tr. 1071-72).

309. NTSP discussed its negotiations with Aetna at an NTSP general membership meeting on November 21, 2000. (CX 180).

310. By Fax Alert #81, dated November 29, 2000, NTSP informed its member physicians that Aetna's then current offer was an across the board fee schedule of 140% of current Medicare RBRVS for its PPO product, an across the board fee schedule of 116% of current Medicare RBRVS for its HMO product, and $40 per unit for anesthesia rates for both the HMO and PPO products. (CX 565).

311. NTSP informed its member physicians in Fax Alert #81:

> In keeping with the minimum compensation standards as conveyed from the membership earlier this year, [Aetna's] PPO offer of 140% of current Medicare approximates an acceptable minimum standard. The minimum standard previously shared by the membership on an HMO product is 125% of current Medicare or

> approximately 9% less than Aetna's present offer. . . .
>
> Because this is a fee-for-service offering falling below the minimum as previously shared via the messenger model to the NTSP Board, we are re-polling the membership on the acceptability of the present Aetna offering.
>
> Please check in the space below what your minimum acceptable range of compensation for the Aetna HMO product is.

(CX 565).

312. The polling ballot listed ranges of rates for selection by NTSP's member physicians. Aetna's offered amounts (116% for HMO, $40-42 per unit for anesthesia) were listed as the lowest "minimum acceptable range of compensation" that NTSP physicians could select on the polling ballot. (CX 565 at 2; Van Wagner, Tr. 1929-30).

313. As reported at NTSP's December 4, 2000 Board meeting, sixty-one responses had been received, with the majority choosing the 121%-130% range. At that meeting, it was also noted that the termination of the contract with Aetna through MSM would be carried out in thirteen days. (CX 74 at 4).

314. On December 8, 2000, NTSP conveyed the poll results to Aetna: "the numbers on the messenger model return for the [HMO] product are

as follows. . . mean: 124.89% of current medicare; mode 127.38% of current medicare; median 123.70% of current medicare." NTSP wrote to Aetna that "this response is essentially the current reimbursement rate for [A]etna [HMO] lives not attached to [MSM]." (CX 571).

315. Aetna then convened an internal meeting and concluded that increasing its offer by 9% to match NTSP's proposal meant losing money on NTSP HMO services. (Jagmin, Tr. 1080).

316. On December 11, 2000, NTSP sent Fax Alert #84 to its member physicians, containing the following statements: "The membership's message that a 125% of current Medicare HMO fee schedule is required has been transmitted to Aetna and a response on this final contractual item is expected within the next 24 to 36 hours . . . . NTSP Continues To Act As Your Agent Both With Aetna Direct And With MSM. At This Point, No Further Action Is Required On Your Part . . . . Please refer all contacts and materials received from either Aetna or MSM to NTSP directly." (CX 573 (*emphasis omitted*)).

(iv) Aetna agrees to NTSP's proposals

317. NTSP wrote to Aetna on December 12, 2000 to inform Aetna that Van Wagner had "polled the Board informally today" and that the NTSP Board "would urge [A]etna to reconsider their position on not accepting the members[']poll results on compensation for the [HMO] direct contract." (CX 578).

318. On December 13, 2000, after receiving instructions from his general manager and regional manager to reject the HMO terms and to attempt to finalize a PPO only contract, Jagmin replied to NTSP, agreeing to proceed with the PPO contract, and stated to NTSP that "the physician expectations for the HMO contracts are not acceptable to Aetna and are rejected."

(CX 580 at 1; *see also* CX 582 at 1; Jagmin, Tr. 1082-83).

319. On December 15, 2000, NTSP received Aetna's final proposed IPA agreement which repeated Aetna's position: "Per your discussion with Chris Jagmin, MD, non HMO based products to be paid at 140% of then current RBRVS per the Fort Worth, TX geographic locality. Anything with no established rate is paid at Company's then current Reasonable Equitable Fee Schedule (REF). Anesthesia services at $40 per unit." (CX 660).

320. The conflict between NTSP and Aetna received publicity in the marketplace. (Jagmin, Tr. 1005-06, 1081-92). Aetna received calls from large employers in Tarrant County such as the Arlington independent school district and other employers and brokers. (Jagmin, Tr. 1083, 1094).

321. On December 18, 2000, Van Wagner reported to the NTSP Board that the PPO arrangement had been completed. Van Wagner referred the Board to a letter from Commissioner Montemayor concerning complaints that the Texas Department of Insurance had recently received from physicians. Van Wagner further "reported that NTSP will continue to negotiate with Celina Burns

[General Manager] of Aetna on an HMO contract. There was a lengthy discussion on an acceptable fee schedule. The membership's response when polled was 125%. The Board instructed NTSP to present 125% on a direct contract." (CX 76 at 2-3).

322. Later on December 18, 2000, Van Wagner wrote to Aetna with a status update that reflected that NTSP's proposal was: for PPO, 140% of current Medicare RBRVS, anesthesia at $45.00; for HMO, 125% of current Medicare RBRVS, anesthesia at $43.00. (CX 585).

323. Ultimately, Aetna agreed to NTSP's terms. On December 19, 2000, Aetna wrote to NTSP and proposed: for PPO, 140% of current Medicare RBRVS, anesthesia at $45.00; for HMO, 125% of current Medicare RBRVS, anesthesia at $43.00. (CX 585 at 1).

324. NTSP responded to Aetna on December 19, 2000, stating that NTSP would send out a notice to its member physicians notifying them that the PPO and HMO offers are within the messenger minimums. NTSP further informed Aetna that it would tell its member physicians that they could choose whether or not to participate in the offerings. (CX 589).

325. In Fax Alert #85, sent to NTSP member physicians on December 19, 2000, NTSP notified its member physicians of the agreed upon rates and stated, "[t]he rates agreed upon for the direct HMO reimbursement and the PPO reimbursement meet NTSP minimum messenger model standards as shared by our members. Because of this, the Board has accepted these reimbursement levels as

appropriate in completing contractual discussions in regards to these products." (CX 586 at 10).

326. NTSP forwarded the NTSP-Aetna contract to its member physicians. (CX 597; CX 615 at 1; CX 611 at 2 ("NTSP is pleased to present two new NTSP contract offerings to all NTSP Members . .")). Ultimately, 188 NTSP member physicians signed the NTSP-Aetna contract. (Jagmin, Tr. 1088).

327. The rates of the NTSP-Aetna contract are increased from Aetna's initial proposal. *Compare* Jagmin, Tr. 1015-16, 1022-24; CX 544 at 2, 3 (for HMO, aggregated to about 111% to 112% RBRVS, and anesthesia at $40 per unit; for PPO, aggregated to about 123% to 125% RBRVS, and anesthesia at $40 per unit) *with* CX 585 (for HMO, 125% RBRVS, and anesthesia at $43 per unit; for PPO, 140% RBRVS, anesthesia at $45 per unit).

328. The rates in the 2000 Aetna-NTSP contract were identical to the Aetna-MSM rates, a contract Aetna had with another IPA. (Jagmin, Tr. 1132-33; Van Wagner, Tr. 1697, 1701-02, 1708-09).

329. Aetna's representative, Roberts, testified that Aetna's reimbursement rates to NTSP were higher than rates for other IPAs for similar services. Roberts also testified that a straight comparison could not be easily made because it depends on the total package of services that an IPA or a physician group might bring to the discussions. (Robert Tr. 472-73).

330. On July 10, 2001, Vance's practice group recorded the following from their practice group's Board of Directors meeting:

> Aetna is now offering a 95% of Medicare contracts for all commercial business. This contract was not presented to a solo practitioner, but to Texas Oncology, a very large corporate entity. This aggressive contracting by Aetna bodes ill for any small entities attempting to contract with Aetna this year. NTSP has been successful in negotiating decent rates from Aetna but only after threatening to term the entire NTSP network last year. As I have argued for a number of years, physicians divided will be cannon fodder in this business. The hope that the Cardiology IPA will protect us from these gorillas is unrealistic. Even a 700 doctor organization such as NTSP may make only a ripple in the water in the coming days but is much more effective than any other organization at this time. Without NTSP's influence this last two years, our market level of reimbursement would be significantly below its present level.

(CX 256).

e. Subsequent contract negotiations

331. On August 10, 2001, NTSP submitted to Aetna a non-risk contract proposal that would incorporate NTSP's medical management and utilization management functions. NTSP's clinical integration proposal incorporated the existing NTSP-Aetna rates (125% for HMO and 140% for PPO of then current Medicare RBRVS) and proposed a contract period of three years. (CX 616; Roberts, Tr. 472-73, 488, 508, 550-51, 560; Van Wagner, Tr. 1709-12).

332. On September 28, 2001, Aetna wrote to NTSP, stating Aetna's intention to continue discussions to finalize a mutually acceptable new agreement before the end of 2001, to commence on February 1, 2002. Aetna's letter terminated Aetna's existing agreement with NTSP, effective January 31, 2002. (CX 644, *in camera*; Roberts, Tr. 489-90).

333. The renegotiation between Aetna and NTSP involved only non-risk components. (Roberts, Tr. 487).

334. On October 8, 2001, the NTSP Board reviewed Aetna's termination letter and decided to continue negotiations with Aetna. (CX 102 at 1-3).

335. Van Wagner informed the Board that Aetna's new proposed rates would be lower and that negotiations would be arduous. (CX 102 at 1-3).

336. On October 15, 2001, the NTSP Board received and accepted the results of the 2001 annual poll. The acceptable contract minimums as

established by the annual poll were 125% of current Medicare RBRVS for HMO and 140% of current Medicare RBRVS for PPO. The Board meeting minutes further reported: "[t]his year's polling of NTSP members as per a messenger model indicates these levels have not changed. The Board accepted this information and instructed staff to use these levels as minimally acceptable fee schedules for HMO and PPO contract offers." (CX 103 at 4-5).

337. On October 29, 2001, NTSP shared the poll results with its member physicians at a general membership meeting at which member physicians also received an update on the ongoing Aetna negotiations. (CX 186).

338. On October 30, 2001, Aetna proposed to NTSP an "Aetna Market Based Fee Schedule. For PCPs and Specialists this is 85% / 115% for the HMO Based Plans and 95% / 129% for the Non-HMO Based Plans." Aetna's "market-based fee schedule" refers to a fee schedule that Aetna uses primarily for individual physicians, but is also used with some IPAs and some groups. (CX 629; Roberts, Tr. 492-93, 568).

339. The rates Aetna offered NTSP on October 30, 2001 were based off of then current Dallas RBRVS. The proposal also included a "steering incentive," a 10% increase to those rates, for physicians in certain speciality areas that steered outpatient procedures to one of Aetna's preferred outpatient surgery centers. (CX 629; Roberts, Tr. 492-93, 568).

340. NTSP rejected Aetna's proposal of a 10% steering fee for some specialties because the

reimbursement methodology would not be applied to all of NTSP's physicians. (Roberts, Tr. 523-24; Van Wagner, Tr. 1771).

341. NTSP never distributed Aetna's October 30, 2001 offer to its membership, lacking Board authority to do so. (Van Wagner, Tr. 1713-14; Roberts, Tr. 495).

(i) NTSP's claims of efficiencies

342. On November 1, 2001, NTSP sent utilization data to Aetna and in an attached letter advocated against a decrease in NTSP's then current fee schedule. NTSP stated: "[a]lthough NTSP's current fee schedule is higher than that proposed by Aetna at the unit cost level, budget to actual PMPM [per member, per month] historical figures indicate that significant savings will accrue to Aetna given historical utilization patterns of NTSP physicians." (CX 553).

343. Aetna believed that it was "critical to [their] organization" to determine if NTSP's efficiency claims were valid. Aetna believed that, "if, in fact, there were efficiencies and we couldn't come to terms [with NTSP], then when those services went to other physicians in the marketplace, then the costs would actually go up . . . so it was critical to us [Aetna] that we do an in-depth review of this data and try to determine if there were efficiencies and, if there were, to make sure this contract continued." (Roberts, Tr. 497).

344. NTSP provided to Aetna data derived from NTSP's risk contract with PacifiCare, though

345. Aetna was not able to run an analysis of NTSP physicians compared to other physicians due to problems with Aetna's own data. (Roberts, Tr. 560-61).

346. Due to the limited data provided by NTSP and deficiencies in Aetna's own internal data, Aetna could neither validate or invalidate NTSP's claims of clinical efficiencies. (Roberts, Tr. 504-05).

(ii) No agreement on non-risk contract

347. On November 6, 2001, Aetna informed NTSP that its analysis of Aetna's own data did not support NTSP's efficiencies claims. "In light of this review of our data, we can not identify significant management objectives that would require any adjustment to [the] proposed fee schedule." (CX 501; Roberts, Tr. 502-03, 524-27).

348. On November 7, 2001, NTSP replied that although negotiations would proceed, "[t]o ask high performing physicians to take pay cuts because others have not done as well will be a difficult sell." NTSP also noted that Aetna would meet with the NTSP Board. (CX 502).

349. On November 12, 2001, Aetna representatives attended an NTSP Board meeting and addressed Aetna's proposal. Aetna offered an overall reimbursement average of 118% for the HMO product and 133% for the PPO contract. (CX 106).

At that Board meeting, NTSP proposed a compromise between the parties at a rate level in the low 120s, which was below NTSP's offer of 125%, but above Aetna's offer of 118%. (Roberts, Tr. 537-39).

350. At the November 12, 2001 Board meeting, NTSP informed Aetna that NTSP had collected signed power of attorney forms from its member physicians. (Roberts, Tr. 540-41).

351. Following the November 12, 2001 Board meeting, NTSP did not distribute Aetna's offer to its member physicians because the offer was below Board minimums. (CX 503; Roberts, Tr. 542-43; Van Wagner, Tr. 1642-43, 1776; Deas, Tr. 2433).

352. On November 19, 2001, the Board reviewed Aetna's latest proposal to NTSP. Van Wagner reported that it was essentially the same proposal, which was less than the minimum rates that the membership had messengered as acceptable. (CX 107 at 2-3).

353. On December 3, 2001, Aetna wrote to NTSP informing it that Aetna believed that NTSP's current level of reimbursement was not competitive and that termination of the Aetna-NTSP agreement would be effective on January 31, 2002. (CX 640).

354. On December 7, 2001, NTSP informed its member physicians that Aetna's proposal fell "below payment rates our members have messengered to NTSP as acceptable to continue negotiations." NTSP informed its members that they may contract directly with Aetna or request that Aetna re-open negotiations with NTSP. (CX 643).

355. There is no current contract between NTSP and Aetna. (Roberts, Tr. 549; Van Wagner, Tr. 1718-19).

356. After terminating the contract, Aetna sent direct offers to NTSP's member physicians. NTSP's member physicians were not prevented from dealing directly with Aetna, and Aetna was able to contract directly with many of the physicians who had been part of the NTSP-Aetna contract. (Roberts, Tr. 544-46; RX 1076; RX 9).

f. Aetna investigated by Department of Justice, Texas Attorney General, and Texas Department of Insurance

357. In June 1999, the Department of Justice sued Aetna over its acquisition of Prudential Insurance Company of America as an attempt to gain improper market power over doctors. (RX 451; RX 3099). NTSP assisted the Department of Justice in that investigation. (RX 451). In December 1999, Aetna signed a consent order. (RX 3100).

358. In May 2000, the Department of Justice investigated Aetna's use of an all-product requirement in its contracts. NTSP was asked to and did assist in this investigation. (CX 57).

359. The Texas Commissioner of Insurance issued admonishment letters to Aetna in December 2000 and October 2001 questioning misrepresentations Aetna and MSM were making in contract discussions and questioning the adequacy of Aetna's provider network. (CX 586; RX 3105 (Aetna

ordered to pay restitution and fines for violations through October of 2001); CX 508 (Aetna's response referencing Commissioner's letter)).

360. The Texas Attorney General issued an Assurance of Voluntary Compliance ("AVC") to Aetna in April 2000. (RX 1302; CX 505). Chris Jagmin, an Aetna medical director, was disciplined in August 2001 for violating the AVC by making false representations. (RX 339). NTSP was notified of the Assurance of Voluntary Compliance with Aetna and of Jagmin's disciplinary notice. (CX 103).

361. NTSP reported several payors, including Aetna, to the Texas Department of Insurance in 2000 and 2001 for prompt pay violations, noncompliance with contracts, and predatory pricing concerns. (Van Wagner, Tr. 1772).

362. In November 2001, the Texas Department of Insurance fined Aetna $1.15 million and ordered it to pay restitution to providers for failing to follow Texas laws on prompt payment and clean claims. (RX 1660; RX 1666; RX 3105).

363. In 2002, NTSP made complaints about Aetna's contracting practices to the Texas Department of Insurance. NTSP also sent a complaint letter to Aetna, with a copy to the Texas Department of Insurance. (CX 507; CX 509; CX 512; CX 513; RX 2325).

F. No Valid Procompetitive Justifications

1. No meaningful efficiencies

364. NTSP is not clinically integrated for patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1878; Casalino, Tr. 2877; Frech, Tr. 1351-52).

365. NTSP does not engage in case management for PPO patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1878).

366. NTSP's medical director has no responsibility for controlling costs for patients covered under NTSP's non-risk contracts. (Deas, Tr. 2552-53).

367. NTSP's medical management committee does not evaluate the care of patients covered under NTSP's non-risk contracts. (Deas, Tr. 2550-51).

368. NTSP's hospital utilization management program does not apply to patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1837-38).

369. NTSP's information systems do not include data for patients covered under NTSP's non-risk contracts. (Van Wagner, Tr. 1837-41; Deas, Tr. 2488). The absence of an electronic medical records system for its non-risk patients prevents NTSP from implementing an effective reminder system for patient care at the point of care. (Casalino, Tr. 2839).

370. NTSP does not operate or refer patients to any disease management programs or patient registries which would improve health care quality for patients with specific, long-term conditions such as diabetes or congestive heart failure for patients covered under NTSP's non- risk contracts. (Casalino, Tr. 2812-14; Van Wagner, Tr. 1834-35, 1877).

371. Disease management programs typically include a nurse case manager who maintains regular contact with each patient; monitors indices of each patient's health; ensures that each patient takes prescribed medications; directs each patient to specialist physicians; and encourages each patient to participate in relevant patient education programs. (Casalino, Tr. 2812-13).

372. NTSP does not provide feedback to physicians concerning patient care under NTSP's non-risk contracts. (Lonergan, Tr. 2722-24).

373. NTSP does not require adherence to its clinical guidelines and protocols for its fee-for-service physicians and patients. (Van Wagner, Tr. 1843-44). NTSP does not provide reminders to physicians at the point of care to employ the guidelines and protocols and does not monitor physicians' adherence to them. (Casalino, Tr. 2837-39; Van Wagner, Tr. 1843-44).

374. NTSP's goal of enhanced teamwork among its physicians is hindered by the lack of pediatricians, obstetricians, and cardiologists in NTSP, forcing NTSP patients needing the services of these core specialists to seek physicians outside of NTSP. (Casalino, Tr. 2854-56).

375. NTSP does not engage in meaningful patient education. The patient education features of its web site were created in 2004, after this Complaint was issued, and are largely limited to links to other public web sites. (Casalino, Tr. 2844-48).

2. No significant spillover benefits

376. NTSP engages in utilization and quality control efforts in connection with two health plan agreements: its risk contract with PacifiCare, and, to a lesser extent, its HMO contract, but not its PPO contract, with Cigna. (Van Wagner, Tr. 1830-54).

377. For an IPA to achieve significant "spillover" benefits from its shared-risk patients to its non-risk patients, it would need to apply organized processes to its non-risk patients. (Casalino, Tr. 2864-65).

378. NTSP is hindered in implementing organized processes for patients under non-risk contracts because it lacks data for these patients. (Casalino, Tr. 2868-69; Frech, Tr. 1352-53).

379. NTSP physicians who do not participate in NTSP's shared-risk contract are unlikely to learn and apply techniques to control costs and to improve quality that are developed or learned in the context of that risk-sharing arrangement. (Casalino, Tr. 2859-60; Frech, Tr. 1353-54).

380. Negotiation of rates in non-risk contracts is not necessary for any efficiencies achieved from NTSP's risk panel to spillover to

NTSP's non-risk panel. (Deas, Tr. 2577 (asserted spillovers from NTSP's risk to fee-for-service contracts are "completely unrelated" to NTSP's setting of minimum contract prices); Frech, Tr. 1347-51 (any spillover is unrelated to setting of Board minimums and joint negotiation)).

III. ANALYSIS AND CONCLUSIONS OF LAW

A. Jurisdiction

The Complaint charges Respondent North Texas Specialty Physicians ("NTSP") with violating Section 5 of the Federal Trade Commission Act, as amended ("FTC Act"). 15 U.S.C. § 45. Section 5(a)(2) of the FTC Act gives the Commission jurisdiction "to prevent persons, partnerships, or corporations . . . from using unfair methods of competition in or affecting commerce . . . ." 15 U.S.C. § 45(a)(2); *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1327 n.2 (7th Cir. 1981). *See also McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 241-42 (1980); *Hosp. Bldg Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 745-46 (1976). The FTC Act defines "corporation" to include "any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members. . . ." 15 U.S.C. § 44. *See also Community Blood Bank v. FTC*, 405 F.2d 1011, 1015-16 (8th Cir. 1969). The FTC Act definition of commerce includes "commerce among the several States." 15 U.S.C. § 44.

The "Commission has only such jurisdiction as Congress has conferred upon it by the Federal Trade Commission Act." *Community Blood Bank*, 405 F.2d

at 1015. When the jurisdiction of the Commission is challenged, the Commission bears the burden of establishing its jurisdiction. *Id.* Respondent has challenged jurisdiction in this case. Respondent's Post Trial Brief ("RPTB") at 33. To establish jurisdiction, Complaint Counsel must demonstrate that NTSP is an association organized to carry on business for its own profit or that of its members. *California Dental Ass'n v. FTC*, 526 U.S. 756, 767 (1999). Complaint Counsel must also demonstrate that the acts of NTSP are in or affect commerce. *McLain*, 444 U.S. at 242.

1. Actions on behalf of members

NTSP is an independent practice association ("IPA") that was formed in 1995 for the purpose of allowing a group of specialist physicians to accept economic risk on medical contracts. F. 17, 37. NTSP subsequently broadened its membership to include primary care physicians ("PCPs") and broadened its functions to include entering into non-risk contracts with health insurance plans. F. 37. Physicians establish their relationship with NTSP by entering into a Physician Participation Agreement ("PPA") with NTSP and by paying a one time fee of $1,000 to NTSP. F. 21, 64. Under the PPA, NTSP negotiates non-risk contracts on behalf of its participants. F. 65-67.

NTSP is incorporated under Texas law as a non-profit entity with no members. F. 17, 19; TEX. OCC. CODE ANN. § 162.001 (Vernon 2004). Respondent asserts, that as a matter of Texas corporation law, the participating physicians of NTSP are not "members." Thus, Respondent argues, because NTSP is a memberless organization, it falls

outside the definition of a "corporation" under the FTC Act and outside the jurisdiction of the Federal Trade Commission. RPTB at 33.

However, courts and the Commission look to the substance, rather than the form of incorporation, in determining jurisdiction under the FTC Act. *See California Dental*, 526 U.S. at 767; *American Med. Ass'n v. FTC*, 638 F.2d 443, 448 (2nd Cir. 1980), *aff'd by an equally divided court, without op.*, 455 U.S. 676 (1982). "[T]he mere form of incorporation does not put [an entity] outside the jurisdiction of the Commission." *Community Blood Bank*, 405 F.2d at 1019.

The substance here, as shown by the evidence, is that NTSP's participating physicians are "members," as that word is used in the FTC Act's definition of corporation. The physicians pay dues, participate in association activities, and elect the Board of Directors. F. 21, 24, 33. They meet periodically in "general membership meetings" to discuss matters in the common interest of all physicians, which sometimes includes the negotiation of health plan contracts. F. 33, 42. NTSP refers to its physicians as "members" in its internal communications. For example, the Board or administrative staff of NTSP routinely sends communications to its member physicians called "Fax Alerts," which report on matters, including matters relating to the business interests of the physicians, and are directed to "NTSP members." *E.g.*, F. 86, 160, 282, 326 ("NTSP is pleased to present two new NTSP contract offerings to all NTSP Members . . .").

These facts demonstrate that NTSP's participating physicians are "members" of NTSP. *Cf. Fed. Election Comm'n v. Nat'l Right to Work Comm.*, 459 U.S. 197, 205-06 (1982) (In construing the term "member" as that term is used in the Federal Election Campaign Act, the Supreme Court held that solicitations to individuals who had previously donated to a non-profit corporation did not constitute solicitation to "members," where the alleged members did not play any part in the operation or administration of the corporation and did not elect corporate officials; where there were no membership meetings; and where alleged members did not exercise any control over the expenditures of their contributions.).

The evidence also shows that NTSP acts for the pecuniary benefit of its "members." As NTSP described in a Fax Alert to "NTSP members," under the Physician Participation Agreement, "NTSP will have the exclusive right, on behalf of its members, to receive all payor offers delivered to NTSP or its members." F. 65. As set forth in the PPA entered into between NTSP and its participating physicians, "NTSP is in the business of contracting with health maintenance organizations, health care networks and other payors to provide health care services through physicians and physician groups who have contracted with NTSP to provide such health care services" and "shall use its best efforts to market itself and its Participating Physicians to Payors and solicit Payor Offers for the provision of Covered Services by Participating Physicians." F. 20, 43. *See also* F. 44 ("NTSP was going to be a group of physicians that would bring a voice to organizing physicians who often practiced in individual groups

to hopefully be able to secure contracts. . . . [I]t was to represent physicians . . . in obtaining contracts from businesses or insurance companies or in dealing with hospitals."). NTSP's analysis of contract language, from both operational and legal perspectives, and communications with payors about the terms of contracts constitutes benefits undertaken on behalf of NTSP's member physicians. F. 45.

Further illustrating pecuniary benefits, in communications to its member physicians, NTSP has expressed satisfaction about its success in negotiating the fees to be paid to its member physicians. For example, an October 9, 2000 "Open Letter to the Membership" from Dr. Vance (then President of NTSP) notes that NTSP "started in an attempt to provide a seat at the table of medical business for the individual specialty physicians in Fort Worth," and reports that "NTSP has provided a consistent premium fee-for-service reimbursement to the members." F. 44.

The evidence shows that NTSP has negotiated fees on behalf of its member physicians under non-risk contracts with health plans, in the course of which it sought increased reimbursement rates or more favorable coverage terms for its member physicians. *Infra* III.D.2. Negotiation of the level of fees that member physicians of NTSP receive for services provided by their own profit-making physician practices has an effect on the revenues and incomes of the member physicians and thus inures an economic benefit to NTSP's member physicians.

The jurisdiction of the Federal Trade Commission extends to non-profit entities when a

substantial part of the entity's total activities provides economic benefits for its members. *California Dental*, 526 U.S. at 767; I*n re American Med. Ass'n*, 94 F.T.C. 701, 994 (1979). As summarized above, NTSP's activities provide pecuniary benefits for its member physicians.

2. Interstate commerce

In addition, NTSP's activities are in or affect commerce, as required by the FTC Act. 15 U.S.C. § 45 (prohibiting unfair methods of competition "in or affecting commerce"). The jurisdiction of the Commission encompasses acts and practices constituting a violation of the Sherman Act. *FTC v. Cement Instit.*, 333 U.S. 683, 690 (1948). The Commission utilizes cases interpreting jurisdiction under the Sherman Act — which regulates agreements "in restraint of trade or commerce among the several States" — in analyzing its own jurisdiction. *E.g., In re Indiana Fed'n of Dentists*, 101 F.T.C. 57, 161 (1983), *rev'd on other grounds*, 745 F.2d 1124 (7th Cir. 1984), *rev'd*, 476 U.S. 447 (1986).

The jurisdictional reach of the Sherman Act (and, thus, the FTC Act), "is coextensive with the broad-ranging power of Congress under the Commerce Clause." *Chatham Condo. Ass'n v. Century Village, Inc.*, 597 F.2d 1002, 1007 (5th Cir. 1979) (citing *Burke v. Ford*, 389 U.S. 320, 321-22 (1967) ("When competition is reduced, prices increase and unit sales decrease . . . . Thus, the state-wide wholesalers' market division inevitably affected interstate commerce.")).

For purposes of establishing antitrust jurisdiction, actions are in or affect commerce if the government demonstrates "a substantial effect on interstate commerce generated by respondents' . . . activity. Petitioners need not make the more particularized showing of an effect on interstate commerce to fix . . . rates, or by those other aspects of respondents' activities that are alleged to be unlawful." *McLain*, 444 U.S. at 242-43. Alternatively, the Supreme Court has stated that to establish federal jurisdiction, "there remains only the requirement that respondents' activities which allegedly have been infected by a price-fixing conspiracy be shown 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved." *Id.* at 246 (quoting *Rex Hosp.*, 425 U.S. at 745).

Although the term used in evaluating the effect on interstate commerce is "substantial" or "not insubstantial," Supreme Court precedent makes clear that an effect on commerce can be viewed as "substantial" even though "its impact on interstate commerce falls short of causing enterprises to fold or affecting market price." *Rex Hosp.*, 425 U.S. at 745. Further, "[w]holly local business restraints can produce the effects condemned by the Sherman Act." *Id.* at 743 (citations omitted).

For example, in *Rex Hospital*, a small proprietary hospital, Mary Elizabeth, brought suit against another hospital, Rex, under Sections 1 and 2 of the Sherman Act, alleging that Rex had conspired with others to block the expansion and relocation of Mary Elizabeth within Raleigh, North Carolina. The Court found an effect on interstate

commerce based upon the allegations in the complaint that the blocked expansion of Mary Elizabeth would cause the following reverberations in commerce: a reduction in the amount of medicine and supplies purchased from out-of-state sellers; diminished revenues from out-of-state insurance companies or the federal government; a decrease in the management service fee paid to its parent company, an out-of-state corporation; and lost revenues to out-of-state lenders who were expected to finance the planned expansion. 425 U.S. at 744.

In *McLain*, the Supreme Court considered the effects on commerce of an alleged conspiracy by real estate brokers to fix brokerage rates in New Orleans. The Supreme Court held that the jurisdictional requirement was satisfied by allegations that the conspiracy affected both the sale of real estate to interstate buyers and the financing of those sales by interstate lenders. 444 U.S. at 245. Although noting that such a conspiracy would probably have an effect on "the frequency and terms of residential sales transactions," *id* at 246, the Supreme Court did not require the plaintiff to demonstrate or allege any particular effect on the overall flow of realty- related commerce into the state. Instead, the Supreme Court explained that jurisdiction would not be defeated "by plaintiffs failure to quantify the adverse impact of defendant's conduct." *Id.* at 243. *See also Goldfarb v. Virginia State Bar*, 421 U.S. 773, 785 (1975) ("once an effect is shown, no specific magnitude need be proved").

Furthermore, "[i]n cases involving horizontal agreements to fix prices or allocate territories within a single State, [the Supreme Court has] based

jurisdiction on a general conclusion that the defendants' agreement 'almost surely' had a marketwide impact and therefore an effect on interstate commerce." *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 331 (1991) (quoting *Burke*, 389 U.S. at 322). In *Summit Health*, the market that was impacted was "the Los Angeles market." *Id.* "In *Burke*, the Supreme Court was willing to assume an effect on interstate commerce where the conduct in question, horizontal market divisions, typically has an anticompetitive effect on interstate commerce." *Chatham Condo.*, 597 F.2d at 1007 (citation omitted).

In addition, the government "need not allege, or prove an actual effect on interstate commerce to support federal jurisdiction." *Summit Health*, 500 U.S. at 331. Though not required to prove an actual effect on interstate commerce to support federal jurisdiction, in this case, as summarized in Section III.D.2., *infra*, Complaint Counsel has demonstrated that NTSP negotiated economic terms of non-risk contracts with health insurance payors. These health insurance payors, United Healthcare ("United"), Cigna Healthcare ("Cigna"), and Aetna Health, Inc. ("Aetna"), are all national health plans, headquartered outside of Texas, that sell health care products throughout the United States. F. 101-03, 195, 197, 259, 262. As such, the health insurance providers' businesses are in interstate commerce. *Indiana Fed'n of Dentists*, 101 F.T.C. at 161.[1] Any

[1] The Commission's holding that the respondent's anticompetitive activity had a substantial effect upon interstate commerce and, thus, that the Commission had jurisdiction over the complaint was not appealed by the respondent. *Indiana Federation of Dentists v. FTC*, 745 F.2d 1124, 1132 (7th Cir. 1984).

increase in fees for physician services paid to physicians, on whose behalf NTSP negotiated increased rates, affects these multi-state companies. F. 102, 104, 196-98, 263-64.

"When determining whether interstate commerce is affected by an alleged violation courts will often examine both the defendant's relationship with interstate markets and the plaintiff's." *Construction Aggregate Transport, Inc. v. Florida Rock Indus., Inc.*, 710 F.2d 752 (11th Cir. 1983) (citing *Rex Hosp.*, 425 U.S. at 741 (local actions by defendants to block relocation of hospital adversely affects interstate commerce with regard to medicines and supplies purchased by plaintiff hospital)); *Lehrman v. Gulf Oil Corp.*, 464 F.2d 26, 34-35 (5th Cir. 1972) (demise of plaintiff's business had impact on interstate flow of goods he would have sold) (alternative holding); *Heille v. City of St. Paul*, 671 F.2d 1134, 1137 (8th Cir. 1982) (examining both plaintiff's and defendant's use of goods manufactured out-of-state) (other citations omitted)).

The Complaint in this case was brought by the Federal Trade Commission, and not by the insurance companies. However, the allegations of the Complaint focused on, and the evidence demonstrated, higher rates paid by the insurance companies. Higher rates and more favorable contract terms directly affect these multi-state companies. *See* F. 102, 104, 196-98, 263-64.

Purchases by a defendant of out-of-state goods are also a factor in determining whether an activity substantially affects interstate commerce. *E.g., Rex Hosp.*, 425 U.S. at 744 (petitioner's purchases of out-of-state medicines and supplies considered in

determining "substantial effect" on interstate commerce); *Miller v. Indiana Hosp.*, 843 F.2d 139, 144 n.5 (3rd Cir. 1988) (defendant hospital's treatment of out-of-state patients, purchase of medical supplies from out-of- state, and receipt of money from out-of-state, including federal funds, satisfies the requirement of effecting interstate commerce); *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696 (4th Cir. 1991) (same). *See also United States v. Robertson*, 514 U.S. 669, 672 (1995) ("[A] corporation is generally 'engaged "in commerce" 'when it is itself 'directly engaged in the production, distribution, or acquisition of goods or services in interstate commerce.") (*per curiam*) (quoting *United States v. Am. Bldg. Maint. Indust.*, 422 U.S. 271, 283 (1975)).

From January 1, 1999 to December 22, 2003, NTSP purchased $1,047,819.86 from vendors with billing addresses outside of Texas. F. 22. For example, NTSP purchased $457,373.09 of stop loss insurance from a California insurance broker. F. 22. These purchases from out-of-state sources illustrate that NTSP is directly engaged in the acquisition of goods or services in interstate commerce. This factor, together with the impact of NTSP's negotiation of rates and economic terms paid by multi-state insurance companies, demonstrates that NTSP's activities substantially affect commerce.

Under the broad jurisdictional scope of "a substantial effect on interstate commerce," the activities of Respondent are in or affect commerce. Thus, the Commission has jurisdiction over NTSP, and the conduct challenged in the Complaint, under Sections 4 and 5 of the FTC Act. 15 U.S.C. §§ 44, 45.

B. Burden of Proof

Under Commission Rule of Practice 3.51(c)(1), "[a]n initial decision shall be based on a consideration of the whole record relevant to the issues decided, and shall be supported by reliable and probative evidence." 16 C.F.R. § 3.51(c)(1). The Commission amended its Rules of Practice, effective May 18, 2001. FTC Rules of Practice, Interim rules with request for comments, 66 Fed. Reg. 17,622 (April 3, 2001). Through the amendments, the Commission removed the requirement of Rule 3.51(c)(3) that the initial decision of an Administrative Law Judge ("ALJ") be supported by "substantial" evidence. 66 Fed. Reg. at 17,626. The Administrative Procedure Act, however, requires that an ALJ may not issue an order "except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence." Administrative Procedure Act ("APA") 5 U.S.C. § 556(d). According to Black's Law Dictionary, "probative evidence" means having the effect of proof; tending to prove, or actually proving an issue. "Substantial evidence" is defined in Black's Law Dictionary as such evidence that a reasonable mind might accept as adequate to support a conclusion. At the adjudicative level of these proceedings, any difference between "probative" evidence and "substantial" evidence is not dispositive under these standards. Therefore, all findings of fact in this Initial Decision are supported by reliable, probative, *and* substantial evidence.

The parties' burdens of proof are governed by Commission Rule 3.43(a), Section 556(d) of the APA,

and case law. FTC Rules of Practice, Interim rules with request for comments, 66 Fed. Reg. 17,622, 17,626 (April 3, 2001). Pursuant to Commission Rule 3.43(a), "[c]ounsel representing the Commission . . . shall have the burden of proof, but the proponent of any factual proposition shall be required to sustain the burden of proof with respect thereto." 16 C.F.R. § 3.43(a). Under the APA, "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." 5 U.S.C. § 556(d). *See also Steadman v. SEC*, 450 U.S. 91, 102 (1981) (APA establishes preponderance of the evidence standard of proof for formal administrative adjudicatory proceedings).

The government bears the burden of establishing a violation of antitrust law. *United States v. E.I. duPont de Nemours & Co.*, 366 U.S. 316, 334 (1961). "[T]he antitrust plaintiff must present evidence sufficient to carry its burden of proving that there was [an anticompetitive] agreement." *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 763 (1984). Accordingly, Complaint Counsel bears the burden of demonstrating that Respondent's actions in this case are anticompetitive.

C. Relevant Market

The relevant market has two components, a geographic market and a product market. *H.J., Inc. v. Int'l Tel. & Tel.*, 867 F.2d 1531, 1537 (8th Cir. 1989). Even in a horizontal price fixing case analyzed under the *per se* rule, the relevant market must be defined. *Bogan v. Hodgkins*, 166 F.3d 509, 515 (2d Cir. 1999) ("[I]t is an element of a *per se* case to describe the relevant market in which we may

presume the anticompetitive effect would occur."); *Double D Spotting Serv., Inc. v. Supervalu, Inc.*, 136 F.3d 554, 558-59 (8th Cir. 1998) ("[A] plaintiff alleging a horizontal restraint must at least define the market and its participants.").

The relevant geographic market is the region "in which the seller operates, and to which the purchaser can practicably turn for supplies." *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961). The relevant product or service market is "composed of products that have reasonable interchangeability for the purposes for which they are produced price, use and qualities considered." *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 404 (1956); *Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 481-82 (1992) (relevant market determined by the choices of products or services available to consumers).

Complaint Counsel argues "that it is unnecessary to define markets or assess market power when conduct is clearly anticompetitive, especially if (as here) there is direct evidence of actual anticompetitive effects (higher prices) as a result of the conduct." Complaint Counsel's Post Trial Reply Brief ("CCPTRB") at 13-14. Cases relied upon by Complaint Counsel hold that market power need not be demonstrated or that anticompetitive *effects* in the market need not be proved. However, these cases do not hold that the market need not be *defined*. *E.g., Todd v. Exxon Corp.*, 275 F.3d 191, 206 (2d Cir. 2001) (finding first that plaintiff has adequately defined the market before holding that "actual adverse effect on competition . . . arguably is more direct evidence of *market power* than

calculations of elusive market share figures") (emphasis added); *Re/Max Intl, Inc. v. Realty One, Inc.*, 173 F.3d 995, 1018 (6th Cir. 1999) ("an antitrust plaintiff is not required to rely on indirect evidence of a defendant's monopoly power, such as high market share within a *defined* market, when there is direct evidence that the defendant has actually set prices or excluded competition") (emphasis added). As Complaint Counsel stated in its brief, "[i]n *Polygram Holding*, the Commission held that it was not necessary to examine evidence of respondent's market power, such as a high market share within a *defined* market, where there is direct evidence of price-fixing among competitors." CCPTRB at 14 (citing *In re Polygram Holding, Inc.*, 2003 FTC LEXIS 120, at *45 n.26 (July 24, 2003) (emphasis added). Market definition and market power are different issues. No one can dispute, with any credibility, that the necessity to first *define* a market is the same thing as a requirement to demonstrate *power* within that already defined market.

Complaint Counsel's expert, Dr. Harry Edward Frech, did not attempt to prove a relevant market. Dr. Frech's testimony on this point could not be more clear:

> Q. And by the way, you're not positing any relevant market in this case, isn't that correct?
>
> A. That's correct.

Frech, Tr. 1393-94. Fortuitously for Complaint Counsel, despite its misguided belief that the market need not be defined, evidence introduced at trial

demonstrates that the relevant market in this case is physician services available to patients in Fort Worth, Texas (the "Fort Worth area"). See F. 52-63.

The evidence shows that primary care physicians and specialists from the Fort Worth area are important to health insurers, employers, and consumers. F. 52-62. In contracting for health plan services, Fort Worth employers demand significant coverage by physicians who practice in Fort Worth and who admit patients to Fort Worth hospitals. F. 52, 54.

Representatives from health insurance plans testified that they would not be able to effectively market their products to Fort Worth employers without a sufficient number of Fort Worth physicians covering various fields of practice in their network. F. 53. One health insurance plan conducted an independent analysis of the importance of NTSP physicians to its Fort Worth area health plan. This analysis revealed that, without NTSP physicians, there would be substantial coverage holes in the Fort Worth area in several areas of specialization. F. 62.

Health plans would not substitute physicians whose services are available in other areas such as Dallas County or the Mid-Cities area to avoid a small but significant Fort Worth area price increase. F. 58. Representatives from health insurance plans also testified that, even if the price of Fort Worth area physician services increased by five percent or greater, they would still need to have various kinds of Fort Worth area physicians included in their health plans to serve Fort Worth employers and consumers. F. 60.

NTSP has approximately 480 participating member physicians, the majority of whom are specialists. F. 32. The vast majority of NTSP physicians are located in the Fort Worth area of Tarrant County, Texas. F. 31. NTSP physicians are a significant presence in the Fort Worth area. F. 61. NTSP physicians make up a large percentage of Tarrant County practitioners in many medical specialties: pulmonary disease (80 percent); cardiovascular disease (59 percent); and urology (69 percent). F. 61. NTSP has stated that a health plan attempting to serve the employees of the City of Forth Worth "would not be able to satisfy employer/employee match or network access standards without NTSP [p]hysicians [p]articipating in the [n]etwork." F. 63.

Accordingly, the evidence establishes that the relevant market is physician services available to patients in the Fort Worth area.

D. Horizontal Agreement

The FTC Act's prohibition of unfair methods of competition encompasses violations of Section 1 of the Sherman Act, which prohibits agreements in restraint of trade. *California Dental*, 526 U.S. at 762 n.3. The Commission relies on Sherman Act law in adjudicating cases alleging unfair competition. *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 451-52 (1986); *In re California Dental Ass'n*, 121 F.T.C. 190, 292 n.5 (1996).

Section 1 of the Sherman Act prohibits "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign

nations . . . ." 15 U.S.C. § 1. The ban on contracts in restraint of trade extends only to unreasonable restraints of trade, i.e., restraints that impair competition. *State Oil Co. v. Khan*, 522 U.S. 3, 10 (1997); *Chicago Bd. of Trade v. United States*, 246 U.S..231, 238 (1918).

To determine whether Complaint Counsel has established that Respondent's actions violate Section 5 of the FTC Act or Section 1 of the Sherman Act, the critical questions are: (1) whether there was a contract, combination, or conspiracy; and, if so, (2) whether the contract, combination, or conspiracy unreasonably restrained trade.

1. Whether there was a contract, combination, or conspiracy

a. Summary of facts

One of NTSP's functions is to messenger to its member physicians the offers that NTSP receives from health insurance providers of fee-for-service, non-risk contracts ("non-risk contracts"). F. 44. NTSP enters into a Physician Participation Agreement ("PPA") with its member physicians. F. 64. The PPA grants NTSP the right to receive all payor offers and imposes on the member physicians a duty to promptly forward those offers to NTSP. F. 65. The PPA also grants NTSP a right of first negotiation with health care payors, with each physician agreeing that he or she will refrain from pursuing offers from a health plan until NTSP notifies him or her that NTSP is discontinuing negotiations with the health plan. F. 65-66. (CX 275 at 24 ("NTSP shall have the right to receive all Payor Offers made to NTSP or Physician . . . If

Physician receives a Payor Offer, . . . Physician will promptly forward such Payor Offer to NTSP for further handling in accordance with the provisions of this Agreement.")).

The Board of Directors of NTSP ("Board") decides whether to send non-risk contract offers to its member physicians based on "Board minimums" F. 83. Board minimums are minimum rates established through NTSP's polling of its member physicians to determine what each physician believes are acceptable fees for non-risk contracts. F. 84, 87. (*E.g.*, CX 1196 ("Every year the Board asks the members to tell them what they consider to be appropriate reimbursement. . . . Once a year we poll the members and get that information from them."). NTSP's polling form asks each physician to disclose the minimum price that he or she would accept to provide medical services pursuant to a fee-for-service HMO or PPO agreement. F. 89. NTSP collects the results and calculates the mean, median, and mode ("averages") of the minimum acceptable fees. F. 93. NTSP then sends to its member physicians "Fax Alerts," that communicate to NTSP physicians the minimally acceptable fee schedules for non-risk health plan contracts. F. 94, 98, 84 (Fax Alert from NTSP to its member physicians informing them of the results of that year's poll and stating that NTSP "utilizes these minimums when negotiating managed care contracts on behalf of its participants"). If a non-risk contract offer falls below the minimally acceptable fee schedule, NTSP, on behalf of its member physicians, rejects the offer by determining to not messenger the offer to its member physicians. F. 68, 83.

NTSP cannot and does not bind any member physician to non-risk contracts. F. 71. The PPA gives NTSP no authority to bind physicians. F. 67. Any non-risk contracts which NTSP has decided to accept are messengered by NTSP to NTSP's physicians for their individual decisions on whether or not to join. *See* F. 71, 72. *E.g.*, F. 189, 326-27.

In the process of negotiations for the provision of physician services under health plans with United Healthcare ("United") and with Aetna Health, Inc. ("Aetna"), NTSP has solicited and obtained powers of attorney from its member physicians, giving NTSP the legal authority to negotiate non-risk contracts with those health plans on behalf of NTSP's member physicians. F. 76-77, 160-61, 302-04. In the process of negotiations with Cigna Healthcare ("Cigna"), NTSP requested that its member physicians sign an authorization form to allow NTSP to serve as its physicians' agent. F. 80, 205.

NTSP has encouraged its physicians to abstain from negotiating direct contracts with health plans and to refer any health plans' offers to NTSP staff in accordance with their participation agreements. F. 78, 168. NTSP's physicians have referred health plans attempting to contract directly with them back to NTSP, with the knowledge that NTSP would reject offers below Board minimum rates. F. 81. Cigna, for example, received forty virtually identical letters from physicians directing Cigna to contact NTSP, rather than the physicians, because NTSP was acting as the physicians' agent in negotiating the non-risk sharing contract in question. F. 206. When United approached

individual physicians to offer direct contracts, United was also referred to NTSP. F. 173.

b. Summary of parties' positions

Complaint Counsel argues that the mere existence of NTSP is a combination that satisfies the combination requirement of Section 1 of the Sherman Act. Complaint Counsel's Post Trial Brief ("CCPTB") at 51 (citing *Alvord-Polk Inc. v. Schumacher & Co.*, 37 F.3d 996, 1009 n.11 (3d Cir. 1994) ("There is . . . authority for the proposition that a trade association, in and of itself, is a unit of joint action sufficient to constitute a section 1 combination."). Complaint Counsel further asserts that the evidence — that NTSP polled and disseminated averaged data on future prices; that NTSP set minimum rates for contracting with health plans based on this data; and that NTSP collected powers of attorney from member physicians — demonstrates that NTSP entered into a "contract, combination or conspiracy" to implement and enforce price and related agreements. CCPTB at 59-60.

Respondent argues that NTSP, as a single entity, is incapable of colluding with itself. Respondent's Post Trial Reply Brief ("RPTRB") at 7-8. Respondent further asserts that, under the *Colgate* doctrine, NTSP has the legal right to refuse to sign and messenger to its member physicians contractual offers that are outside NTSP's business model. RPTB at 18, 22 (citing United States v. Colgate & Co., 250 U.S. 300, 307 (1919)).

c. Analysis

(i) Concerted action must be demonstrated

To establish a violation of Section 1 of the Sherman Act, a plaintiff must demonstrate concerted action. *Viazis v. Am. Ass'n of Orthodontists*, 314 F.3d 758, 761 (5th Cir. 2002). "The term 'concerted action' is often used as shorthand for any form of activity meeting the section 1 'contract, combination or conspiracy' requirement." *Alvord-Polk*, 37 F.3d at 999 n.1 .

In *Viazis*, the Court of Appeals for the Fifth Circuit held, "[d]espite the fact that 'a trade association by its nature involves collective action by competitors, it is not by its nature a 'walking conspiracy', its every denial of some benefit amounting to an unreasonable restraint of trade.'" 314 F.3d at 764 (quoting *Consolidated Metal Prod, Inc. v. Am. Petroleum Inst.*, 846 F.2d 284, 293-94 (5th Cir. 1988)). Simply because NTSP is an organization of otherwise competing physicians does not mean that the concerted action requirement of Section 1 of the Sherman Act has automatically been satisfied. Indeed, in *Alvord-Polk* the case relied upon by Complaint Counsel, the Court of Appeals for the Third Circuit held, "concerted action does not exist every time a trade association member speaks or acts. Instead, in assessing whether a trade association (or any other group of competitors) has taken concerted action, a court must examine all the facts and circumstances to determine whether the action taken was the result of some agreement, tacit

or otherwise, among members of the association." 37 F.3d at 1007-08.

(ii) Agreement under Maricopa

In *Arizona v. Maricopa Co. Med Soc'y*, 457 U.S. 332, 356-57 (1982), the complaint challenged agreements among competing physicians, who were members of medical societies or medical foundations, that set, by majority vote, the maximum fees that the physicians could claim in full payment for services to policyholders of specific health insurance plans approved by the foundations. While the Supreme Court's opinion provides little detail on the challenged agreements, more detail is available in the lower court decisions. As described by the Court of Appeals, "[t]he challenged conduct is the setting by majority vote of maximum fees that physician members may claim in full payment for health services they provide to policyholders of [certain] approved insurance plans." *Arizona v. Maricopa Co. Med. Soc'y*, 643 F.2d 553, 554 (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982). Further, the Court of Appeals noted that the foundations' "activities include polling their members from time to time to set upper limits on fees they may charge patients covered by insurance plans the [medical societies] approve." *Id.* at 554-55. At the district court level, the court found, "[i]t is undisputed that the foundations set the maximum amount to be paid [to] physicians who agree to provide services to patients who are enrolled in insurance plans approved by the foundations. It is further undisputed that the doctors who agree to participate in the foundation-approved plans are free to set the

prices they charge their patients." *Arizona v. Maricopa Co. Med. Soc'y*, 1979 U.S. Dist. LEXIS 11918, at *2 (D. Az. 1979), *aff'd*, 643 F.2d 553. (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982). As described by the Courts of Appeals for the Fourth Circuit and for the Ninth Circuit, the illegal agreements in *Maricopa* were the agreements by the participating physicians to accept set amounts that had been determined by the foundations as fees in payment for physician services to policyholders. *Ratino v. Med Serv.*, 718 F.2d 1260, 1270 (4th Cir. 1983); *Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022, 1027 (9th Cir. 1988).

The Supreme Court in *Maricopa* found these agreements to be a "combination . . . [that] permitted [the physicians] to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care." 457 U.S. at 356. Thus, the Supreme Court found concerted action without finding that the competing physicians agreed directly with each other to set prices and even where the participating physicians were free to set their own prices. *See id.* In so holding, the Supreme Court noted that the rule against price fixing "is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases." *Id.* at 348.

In this case, there is no evidence that one or more of the member physicians agreed with each other to reject a non-risk payor offer; there is no evidence that one or more of the member physicians

consulted with each other when responding to polls or making decisions on non-risk payor contracts; and, there is no evidence that any member physician knew what another physician was going to do in response to a non-risk payor offer. F. 73-75. However, *Maricopa* does not require such evidence.

The evidence in this case does establish that Respondent entered into agreements with physicians to negotiate non-risk contracts on behalf of those physicians and that physicians agreed to accept the rates of the non-risk contracts entered into between NTSP and health care payors. F. 44, 51, 64, 191, 326. Respondent argues that NTSP physicians at times signed contracts with certain health plans, individually or through other physician groups, at rates different than those agreed to by NTSP. RPTB at 19. However, a price fixing conspiracy need not be perfect or complete in order to be unlawful. *In re High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d 651, 656 (7th Cir. 2002) ("An agreement to fix list prices is . . . a per se violation of the Sherman Act even if most or for that matter all transactions occur at lower prices.").

The evidence further establishes that the physicians, who are otherwise competitors of each other (F. 35-36), provided to NTSP the minimum prices that each physician or physician group would be willing to accept on a non-risk contract specifically for NTSP's use in negotiating the economic terms of non-risk contracts. F. 87-90, 96-98, 155-59, 308-16. *E.g.*, F. 88 ("NTSP polls its affiliates and membership to establish Contracted Minimums. NTSP then utilizes these minimums when negotiating managed care contracts on behalf

of its participants."). And, the evidence establishes that NTSP used this price information to obtain more favorable rates or contract terms from health insurance payors than the payors initially offered. F. 44, 170-90, 317-30. This behavior satisfies the concerted action requirement under *Maricopa*.

In addition, the evidence establishes that NTSP sought a uniform rate for all of its specialties, regardless of the supply or demand for specific specialty services in the market. F. 291, 293, 340. This behavior is contrary to the Supreme Court's finding in *Maricopa* that the rule against price fixing was violated by a price restraint that tended to provide the same economic rewards to all practitioners, regardless of skill or experience. *Maricopa*, 457 U.S. at 348.

The challenged concerted action in this case is similar to the agreement challenged in *Hassan v. Indep. Practice Assoc., P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988). In *Hassan*, an organization of physicians and osteopaths set a maximum fee schedule that was initially based on schedules submitted by members, as well as information about fees in areas in which the organization did not operate. *Id.* at 681-82. The court concluded that, where the association and the board of directors which set the fees were made up of physicians or osteopaths, health care providers set the fee reimbursement and that, under *Maricopa*, there was an agreement between competitors. *Id.* at 687.

If, as in *Maricopa*, it is unlawful for competing physicians to set maximum prices, then, for even stronger reason, it is unlawful for competing physicians to set, through NTSP, minimum prices.

See United States v. Socony-Vacuum Oil Co., Inc., 310 U.S. 150, 223 (1940) ("Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*.").

(iii) Actions on behalf of members

Respondent asserts that NTSP is a single entity, incapable of colluding with itself. RPTRB at 7-8. "It is not sufficient to assert, as defendants do, that a corporation cannot conspire with itself. We must look at substance rather than form." *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476, 480, 481 (4th Cir. 1980) (finding action in concert where "in a real and legal sense, [defendants] are agents of their member physicians"). The substance here is that NTSP, in 'negotiating economic terms of non-risk contracts, did so for the pecuniary benefit of its member physicians. *Supra* III.A.1. *E.g.*, F. 84 (NTSP utilizes these minimums determined by polls "when negotiating managed care contracts *on behalf of its participants*.") (emphasis added).

Respondent is an association of individual competing physicians who have not integrated their medical practices and who have separate and distinct economic interests. F. 18, 35. Where "[e]ach doctor practices medicine in his or her own individual capacity[,] each is a 'separate economic entity potentially in competition with other physicians." *Capital Imaging Associates, P.C. v. Mohawk Valley Med. Ass'n, Inc.*, 996 F.2d 537, 544 (2nd Cir. 1993) (quoting *Bolt v. Halifax Hosp. Med.*

Ctr., 891 F.2d 810, 819 (11th Cir. 1990). *See also Oregon Physicians' Serv.*, 868 F.2d at 1024, 1030 (denying summary judgment where plaintiff produced sufficient evidence to permit a trier of fact to conclude that an organization founded by physicians that offered and administered a prepaid health care plan was an organization of physicians or an agent of its member physicians and may have acted for the anticompetitive interests of its member physicians).

Respondent not only is an entity composed of physicians, it is managed by a Board composed of eight physicians, elected by physicians. F. 23-24. Physician control of NTSP further undermines Respondent's argument that NTSP is a single entity with a unity of purpose. *Virginia Academy of Clinical Psychologists*, 624 F.2d at 481 (physician control of prepaid health care plans sufficient to bring its actions within the purview of Section 1 of the Sherman Act). *See also Addino v. Genesee Valley Med. Care, Inc.*, 593 F. Supp. 892, 894, 896-97 (W.D.N.Y. 1984) (where board of non-profit corporation composed of half physicians and half laypersons approved all proposed rates for physician services, plaintiffs' allegation that defendant was merely a vehicle for the member physicians to fix prices was held to be more than sufficient to state a claim of conspiracy between and among defendant's member physicians); *cf. Barry v. Blue Cross of California*, 805 F.2d 866, 869 (9th Cir. 1986) (where plaintiffs failed to produce any evidence of physician control of the price-setting entity, court upheld the agreement as to prices and reimbursement).

Accordingly, NTSP is not a single entity with a "complete unity of purpose," incapable of conspiring with itself. *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 772 (1984) (no concerted action where a parent company and wholly owned subsidiary had a "'unity of purpose or a common design'") (citation omitted).

(iv) Respondent's authority

Relying on *Viazis*, Respondent argues that Complaint Counsel has failed to establish concerted action. RPTB at 16. In *Viazis*, plaintiff, an orthodontist, claimed that the action taken by an association of orthodontists to suspend plaintiff's membership in the association was concerted action, in violation of Section 1 of the Sherman Act. 314 F.3d at 761. After a hearing and appeal, the association's ethics committee found that plaintiff had violated the association's prohibition of false and misleading advertising and determined to suspend plaintiff's membership in the organization for one year. *Id.* at 761, 764. The Court of Appeals for the Fifth Circuit held that the suspension of plaintiff could "constitute action pursuant to a conspiracy only if the members of [the association] were conspiring among themselves." *Id.* at 764. Plaintiff "was unable to demonstrate that the ethics proceedings against him were a sham or that the standards applied were pretextual, so he failed to establish the existence of an unlawful conspiracy." *Id.* at 764-65.

In *Viazis*, the plaintiff presented no evidence that the proceedings against him were in any way designed to limit competition. *Id.* In this case, the

evidence demonstrates that NTSP engaged in conduct that had the purpose and effect of limiting price competition among NTSP physicians and raising rates above those initially offered to NTSP on non-risk contracts. *E.g.*, F. 187, 327. Accordingly, *Viazis* does not compel a finding that NTSP did not engage in a contract, combination, or conspiracy.

Respondent also asserts that, under *Colgate*, 250 U.S. at 307 (establishing manufacturer's right to refuse to deal) and *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 124 S. Ct. 872, 880-81 (2004) (establishing network's right to refuse to make itself available), NTSP has a right to follow its own business model and to refuse to sign and messenger contractual offers that fall below Board minimums. RPTB at 22. Respondent further asserts that the Court of Appeals for the Fifth Circuit recently reiterated the right of an association to refuse to deal in its *Viazis* decision. RPTB at 22.

In *Colgate*, the United States Supreme Court held that a manufacturer has a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently. 250 U.S. at 307. *Colgate* involved the unilateral decision by a single corporation, Colgate, not to sell its products to dealers who would resell them at prices below the suggested prices set by Colgate. *Id.* at 302-03. As a single corporation, in fact and in form — unlike NTSP — Colgate could not conspire with itself. But here, where NTSP is not an entity with unity of purpose, *Colgate* is inapplicable. *See St. Bernard General Hosp., Inc. v. Hosp. Serv. Ass'n, Inc.*, 712 F.2d 978, 986-87 (5th Cir. 1983) (*Colgate* doctrine

inapplicable to an association comprised of nine local hospitals).

Trinko is likewise inapplicable to the facts of this case. In *Trinko*, the Supreme Court addressed conduct by a single firm charged with monopolization under § 2 of the Sherman Act, not with "contract, combination or conspiracy" under § 1 of the Sherman Act. *Trinko*, 124 S. Ct. at 878. There was no allegation that the defendant had agreed with any other person on prices or on a refusal to deal. *See id.* The Court in *Trinko* held that the defendant was not required to make its communication network available to competitors. *Id.* at 880. The Court's holding reflects the reluctance of courts to use the antitrust laws to force competitors to cooperate with one another, recognizing that such cooperation may instead lead to collusion or reduce incentives to innovate. *Id.* at 879. Thus, *Trinko* is inapposite to a case such as this, involving an agreement on prices and concerted action.

Viazis also does not compel a conclusion that NTSP has a right to refuse to sign and messenger contractual offers that fall outside NTSP's business model. In *Viazis*, the Fifth Circuit held that a plaintiff cannot show competitive harm "merely by demonstrating that the defendant refused without justification to promote, approve, or buy the plaintiff's product.'" 314 F.3d at 766 (quoting *Consolidated Metal Products*, 846 F.2d at 297). Respondent asserts that this case is similar to *Viazis* in that NTSP is making a decision on whether or not it wants to be involved in (*i.e.*, "approve") a payor's offer. RPTB at 22. What makes this case different, however, is that the court in *Viazis* found that there

was no evidence that the association had influence over its members' purchasing decisions or that it coerced them into rejecting plaintiff's product. 314 F.3d at 766. Here, there is evidence that NTSP influenced its member physicians to allow NTSP to negotiate economic terms of non-risk contracts on their behalf and that NTSP rejected offers that fell below Board minimum rates which NTSP had set based upon polling the member physicians. *E.g.*, F. 65-67, 70, 83-89, 127, 155-57, 300, 311-16.

(v) Summary

Complaint Counsel has presented evidence "that tends to exclude the possibility that the alleged conspirators acted independently." *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986) (quotation omitted). The evidence, as detailed in the Findings of Fact and summarized above, establishes that NTSP and its member physicians entered into agreements to allow NTSP to negotiate on behalf of its member physicians; that NTSP established Board minimum rates by polling its member physicians to determine the minimally acceptable rate that its member physicians would accept for physician services; that NTSP used these Board minimum rates in negotiating the economic terms of non-risk contracts with health insurance plans; and that NTSP obtained for its member physicians more favorable rates or contract terms from health insurance payors than the payors initially offered. Accordingly, Complaint Counsel has demonstrated concerted action. The next required inquiry is whether Respondent's actions unreasonably restrained trade.

2. Whether there was an unreasonable restraint of trade

a. Summary of facts

A review of the actions NTSP took in its negotiation of economic terms of non-risk contracts with three health insurance payors — United, Cigna, and Aetna — demonstrates that the concerted action taken by NTSP was an unreasonable restraint of trade. As detailed in the Findings of Fact and summarized below, NTSP, on behalf of its member physicians, negotiated economic terms on non-risk contracts and entered into agreements with health care payors through which NTSP obtained higher rates or more beneficial economic terms than the health care payors initially offered to NTSP. NTSP has not demonstrated valid procompetitive justifications for this conduct. Thus, as set forth below, Complaint Counsel has demonstrated an unreasonable restraint of trade.

(i) Negotiations of economic terms with health plans

The Medicare RBRVS fee schedule is Medicare's Resource Based Relative Value System ("RBRVS"), a system developed by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for each service rendered to Medicare patients. F. 10. Health plans that contract with physicians on a fee-for-service basis often do so based on a stated percentage of the Medicare RBRVS fee schedule, which provides reimbursement rates for a large number of specific procedures. F. 11. The Medicare

RBRVS establishes weighted values for each medical procedure, such that the application of a percentage multiplier enables one to determine the fees for thousands of different services simultaneously. F. 12.

NTSP's polling form, which asks each physician to disclose the minimum price that he or she would accept for the provision of medical services pursuant to a fee-for-service HMO or PPO agreement, asks member physicians to indicate their price selection by placing a check mark next to one of several pre-printed Medicare RBRVS ranges. F. 89-90. On October 15, 2001, the NTSP Board received annual poll results. F. 96. Based on the poll results, NTSP established minimum prices of 125% of 2001 Medicare RBRVS for HMO products and 140% of 2001 Medicare RBRVS for PPO products as minimally acceptable fee schedules. F. 96. On November 11, 2002, NTSP conducted another annual poll to determine minimum reimbursement rates for use in negotiation of HMO and PPO products and anesthesia contracts with health plans. F. 97. On its 2002 polling form sent to physicians, NTSP included the 2001 poll results, reported by mean, median, and mode. F. 97. The results of the 2002 annual poll by mean, median, and mode, for HMO were 131%, 135%, and 135%; for PPO, 146%, 145%, and 145%. F. 98. As summarized below, these minimum rates were used by NTSP in its negotiation of economic terms of non-risk contracts on behalf of its member physicians.

• United

In June 1998, NTSP sought to negotiate a non-risk contract with United, a health care payor

that had been identified by NTSP as a potential major player in the market place. F. 107-08. To that end, NTSP solicited powers of attorney from its member physicians and recommended that the physicians "refrain from responding to United Healthcare while NTSP's request for agency status is being tabulated." F. 108, 110. In the course of its negotiations with United, NTSP made fee proposals to United and instructed its member physicians not to take any actions with respect to a United contract because NTSP was engaged in negotiations with United on behalf of NTSP's member physicians. F. 112-13. In the fall of 1998, United made an offer to NTSP on a non-risk contract containing rates that were below the rates available to physicians through another IPA, Health Texas Provider Network ("HTPN"). F. 116. NTSP and HTPN had an arrangement whereby NTSP physicians would be allowed to access HTPN's payor offers. F. 117. NTSP proposed to United that NTSP's member physicians contract with United through HTPN, which allowed higher rates than those offered to NTSP by United. F. 118-19. A significant number of NTSP physicians did access United through HTPN. F. 120.

In March 2001, NTSP approached United to negotiate a direct NTSP-United non-risk contract. F. 121. At that time, United already had contracts with approximately two-thirds of NTSP's member physicians, either directly or through other physician organizations such as HTPN. F. 124. Therefore, United concluded that there was no real need to enter into a contract with the remainder of NTSP physicians through an NTSP group contract. F. 124. Nevertheless, United offered NTSP its then

standard rate in the Fort Worth area of 110% of 2001 Dallas RBRVS, which was the equivalent of 115% of 2001 Tarrant County RBRVS. F. 126. Without presenting the offer to its member physicians, NTSP informed United that the offer was unacceptable because it fell below NTSP's Board minimums and because it offered a single rate for both HMO and PPO products, instead of different rates for the two products. F. 127, 129, 147. In a Fax Alert to the member physicians, NTSP's Board informed its member physicians that NTSP and United had agreed to fundamental non-economic terms, but that NTSP believed that United's rate offer was lower than NTSP's minimum price level. F. 149.

Following its rejection of the United offer, NTSP contacted a large employer, the City of Fort Worth, which was engaged in contract negotiations with United to provide health care coverage to the employees of the City of Fort Worth. F. 140, 141, 144. In July 2001, NTSP sent a letter to the Mayor of Fort Worth notifying him that United's reimbursement rates are "well below market benchmarks" and that "NTSP simply has not and will not accept United's request for our participation in their provider network for your employees." F. 138. The letter also stated that "the City may experience significant network disruption once United officially begins their duties (up to 588 doctors no longer available)." F. 138. NTSP encouraged its Board members to "contact any city council members they know to let them know that United's panel is not adequate." F. 135. NTSP also urged its primary care physicians to contact the Mayor and city council members to educate them

about the situation with United and ask for assistance. F. 136.

These actions created concern among United's client, the City of Fort Worth, that NTSP physicians might drop out of United's network, leaving an inadequate network of physicians to serve its Fort Worth-based employees. F. 143. Based on these concerns, the City of Fort Worth urged United to do what was necessary to preserve its provider network. F. 143.

United, because it had a majority of NTSP physicians already under contract through HTPN, did not initially increase its offer to NTSP in the summer of 2001. NTSP, in July 2001, informed United that NTSP intended to terminate the contract that NTSP had with HTPN for the provision of physician services to United. F. 153. *See also* F. 150 (Fax Alert informing NTSP member physicians that "the NTSP Board has authorized termination [of] the United Health Care contract. However, notice has not yet been sent to United as NTSP must attempt one last strategy."). Subsequently, on July 23, 2001, the NTSP Board approved termination of NTSP's participation in the United-HTPN contract, effective October 20, 2001. F. 151.

In addition, NTSP solicited powers of attorney from its member physicians to enable NTSP to negotiate contracts between the physicians and United on the physicians' behalf. F. 160. Under the broad language of the power of attorney, NTSP was authorized to negotiate price terms on behalf of the member physicians: "[t]his power of attorney grants the authority to the agent to act on the undersigned's behalf regarding the foregoing

described agreements in all respects, including the authority to negotiate the terms of, enter into, execute, amend, modify, extend or terminate any such agreements." F. 161.

United learned about NTSP's efforts to solicit powers of attorney from NTSP's member physicians. F. 162. This effort, in conjunction with NTSP's termination of 108 physicians participating in United via HTPN and the concerns expressed by the City of Fort Worth to United about losing NTSP physicians from United's provider network, induced United to change its network strategy for Tarrant County. F. 162. Initially, United tried to recruit the terminated NTSP member physicians individually. F. 163. United directly offered those physicians the opportunity to return to a United contract at the same reimbursement rates that they had received under the HTPN-United agreement prior to their termination by NTSP. F. 164.

NTSP sent another Fax Alert to its member physicians in August 2001. In it, NTSP explained that it had been receiving calls from member physicians regarding direct offers that they had received from United; repeated NTSP's assessment that the United offer fell below Board minimums; noted that NTSP had already received 107 executed powers of attorney from its member physicians "to act on their behalf in regard to all contracting activity between themselves and United Healthcare"; invited the submission of executed powers of attorney by other member physicians; and advised member physicians who had already signed powers of attorney to inform United representatives that NTSP was their contracting agent and to

instruct United "to contact NTSP directly." F. 165-68. NTSP promised its member physicians that it would continue to pursue a direct contract with United that "meets or exceeds" the fee schedule minimum rates set by NTSP membership. F. 166.

United was not successful in signing contracts directly with NTSP physicians. United's initial direct contract invitation attracted only a few physicians, even though the physicians were offered the same rates that they previously received through HTPN. F. 171-72. Some of these physicians who rejected United's offer explicitly referred United back to NTSP as their negotiating agent. F. 173.

After receiving little interest in its initial direct offer to the terminated NTSP physicians, United tried to work through other Fort Worth IPAs or large medical groups. United offered 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO to two other IPAs, All Saints Affiliates and Medical Clinic of North Texas. F. 170. Next, United offered NTSP a rate of 125% of 2001 Tarrant RBRVS for HMO and 130% Tarrant RBRVS for PPO. F. 185.

NTSP and United signed a contract for 125% of 2001 Tarrant County RBRVS for HMO and 130% of 2001 Tarrant County RBRVS for PPO, effective November 1, 2001. F. 186. On November 1, 2001, NTSP sent the contract to its member physicians to opt in or opt out, indicating that the contract was a result of negotiations and that the 125% of the 2001 Tarrant County RBRVS for the HMO was "at the average level of acceptable reimbursement," but that the PPO rate of 130% was below the acceptable average reimbursement levels determined by the

NTSP Board based on the poll results. F. 189. Of NTSP's member physicians, for HMO, 24% accepted, and for PPO, 23% accepted the NTSP-United contract. F. 191.

• Cigna

Cigna purchased Healthsource, Inc. ("Healthsource") in late 1997 and informed physicians in Healthsource's network that their contracts with Healthsource would be assigned to Cigna. F. 201-02. NTSP physicians who had contracts with Healthsource, at NTSP'S direction, sent Cigna forty virtually identical letters, representing fifty-two doctors in separate practice groups, refusing assignment and stating that NTSP would be their representative and agent in negotiations with Cigna. F. 204-06.

Cigna and NTSP entered into a Letter of Agreement ("LOA") in October 1999, through which Cigna agreed to reimburse NTSP specialists, with the exception of cardiologists/CV [cardiovascular] surgeons, gastroenterologists, urologists, oncologists, and podiatrists, on a fee schedule equal to 125% of the 1998 Dallas County RBRVS. F. 212-13. Subsequently, NTSP requested, and Cigna agreed to, an amendment to the contract that insured that the rate would be adjusted annually to maintain 125% of current year RBRVS. F. 220.

Under the October 1999 LOA, Cigna entered into a non-risk contract for "NTSP specialists." F. 213, 237. Subsequently, NTSP asked Cigna to allow primary care physicians to "opt in" to the NTSP-Cigna contract. F. 238. Cigna already had an adequate number of primary care physicians in its

network and determined that if NTSP's primary care physicians were allowed into Cigna's network, Cigna's overall costs would increase without any benefit to Cigna. F. 239. At times during the negotiations, in late 2000, regarding the inclusion of primary care physicians, NTSP threatened to terminate the NTSP-Cigna contract. F. 244. Cigna eventually agreed to allow NTSP's primary care physicians to opt in to the existing contract. F. 246.

In preparation for its negotiations with NTSP, Cigna analyzed the importance of having NTSP's physicians in its Fort Worth area network. F. 235. Cigna determined that NTSP's physicians made up a high percentage of many specialty practices. F. 235. Cigna also performed disruption analyses to determine the effect of losing access to NTSP's physicians. F. 235. Based on these analyses, Cigna concluded that a loss of NTSP physicians would have a significant negative impact on Cigna's network in several crucial specialties, and that, therefore, it must have those physicians in its Fort Worth area network. F. 235. Cigna also concluded, based on the identical letters it received from NTSP's member physicians designating NTSP as their agent and the threats by NTSP to terminate its contracts with Cigna, that NTSP's physicians would only contract through NTSP and would not agree to contract individually with Cigna. F. 206, 208.

Under the contract between Cigna and NTSP that was current at the time of trial, April 2004, PPO reimbursement is at a rate of { } and HMO reimbursement is at a rate of { }. F. 250 (in camera). Cigna agreed to allow NTSP's primary care physicians to opt in to the contract on a fixed amount

per patient basis and to provide for the future inclusion of specialists who had previously been carved out of the Cigna HMO contract. F. 246. There is insufficient evidence to determine if NTSP's demand of these rates was based on Board minimums or poll results.

• Aetna

Prior to 2000, many NTSP physicians served Aetna patients in the Fort Worth area through contracts that NTSP's physicians had with Medical Select Management ("MSM"), an IPA to which Aetna had delegated almost all medical risk for HMO care. F. 267, 269, 273-74. In 1999 and again in 2000, NTSP approached Aetna to obtain a direct NTSP-Aetna contract that would not involve MSM. F. 276-77. Initially, NTSP and Aetna tried to negotiate a risk contract, but after those negotiations reached a dead end, in October 2000, their negotiations shifted to non-risk, fee-for-service HMO and PPO products. F. 286.

In their negotiations on the terms of a non-risk contract, Aetna initially offered to NTSP rates that were based on a reference schedule that uses the same relative value units from the RBRVS schedule, but places a different multiplier on different specialties' services, based on supply and demand. F. 288. Aetna's initial offer aggregated to about 111% to 112% RBRVS for HMO and about 123% to 125% RBRVS for PPO, with some specialities being offered more or less than the aggregate. NTSP rejected this offer and proposed, instead, uniform rates for all specialities of 125% RBRVS for HMO and 140% RBRVS for PPO. F. 288. In November 2000, Aetna, in response to NTSP's

demands, agreed to raise its PPO offer to 140% and offered a higher HMO reimbursement rate of 116%. F. 298. NTSP accepted the offered PPO rates, but continued to insist on the higher rate of 125% for its HMO contract. F. 299, 300.

In the midst of negotiating the HMO rates with Aetna, NTSP decided to re-poll its member physicians "on the acceptability of the present Aetna offering." F. 311. Shortly thereafter, NTSP informed its member physicians that "[t]he membership's message that a 125% of current Medicare HMO fee schedule is required has been transmitted to Aetna and a response on this final contractual item is expected within the next 24 to 36 hours." F. 316. NTSP further informed its member physicians that NTSP continued to act as their agent and instructed its member physicians to refer all contacts and materials received from Aetna to NTSP directly. F. 316.

During these negotiations, Aetna was subjected to pressure to reach an agreement with NTSP. In June 2000, NTSP threatened that its member physicians might immediately end their participation in the Aetna-MSM arrangement. F. 278. NTSP also sought and received approximately 180 powers of attorney from its member physicians, authorizing NTSP to act for those physicians in all transactions relating to MSM and to represent its member physicians in any negotiations with Aetna, regarding any term. F. 304. Using the authority provided by the powers of attorney, in November 2000, as previously threatened, NTSP terminated its member physicians' participation in the Aetna-MSM arrangement, citing breach of contract by MSM. F.

297. Based on the language of the powers of attorney and other NTSP statements to Aetna, Aetna believed that it could not negotiate directly with NTSP physicians. F. 306.

Ultimately, Aetna agreed to NTSP's terms. On December 19, 2000, Aetna wrote to NTSP and proposed for PPO, 140% of current Medicare RBRVS, anesthesia at $45.00; for HMO, 125% of current Medicare RBRVS, anesthesia at $43.00. F. 323. NTSP responded, stating that NTSP would send out a notice to its member physicians notifying them that the PPO and HMO offers were within the messenger minimums. F. 324. NTSP forwarded the NTSP-Aetna agreement to its member physicians. F. 326. One hundred and eighty-eight member physicians agreed to the NTSP-Aetna contract. F. 326.

In 2001, Aetna attempted to reduce the rates it paid to NTSP. F. 331. Aetna offered NTSP rates that Aetna believed were more in line with the market, but in some aspects were higher than Aetna's general fee schedule. F. 338-39. NTSP did not present Aetna's rate proposal to its member physicians because NTSP did not have Board authority to do so. F. 341. The Aetna-NTSP contract was terminated at the beginning of 2002. F. 332.

(ii) Effects on prices

The evidence establishes that NTSP, through its coordinated efforts, was able to demand higher prices from United and Aetna and more favorable terms in its contract with Cigna, than those health insurance payors initially offered. However, there is

insufficient evidence to establish that the rates that United, Cigna, and Aetna agreed to with NTSP are uniformly higher than rates health insurance payors offered to other IPAs or directly to other physicians.

Several health plans estimated that they had paid increased prices as a result of NTSP's negotiation of economic terms of non-risk contracts. United agreed to a contract with rates that were an increase of 10% from their initial HMO offer and an increase of 15% from their initial PPO offer. F. 187. However, the rate that United offered to NTSP was the same rate that United had offered other IPAs. F. 188. Cigna estimated that it would cost { } to shift some of its direct-contracted physicians from market compensation to NTSP compensation. F. 248 (*in camera*). Cigna's representative testified that the reimbursement rate of 125% of RBRVS on HMO and 130% of RBRVS on PPO was somewhere between 15 and 20 percent higher than Cigna's standard rates. F. 217. However, Cigna's representative also testified that the rates that Cigna paid to NTSP were in the "general ballpark" of the rates Cigna paid to other IPAs { } F. 217 (*in camera*). Aetna agreed to contract rates for 2000 (uniform rates of 140% RBRVS for PPO and 125% RBRVS for HMO) that were higher than the rates Aetna initially offered (aggregated to about 123% to 125% RBRVS for PPO and to about 111% to 112% RBRVS for HMO). F. 327. Although Aetna's representative testified that the rates in the 2000 Aetna-NTSP contract were higher than other IPAs for similar services, those rates were identical to the rates in the Aetna-MSM contract. F. 328-29.

Complaint Counsel, in its post trial brief, argues that NTSP had compared the rates that its physicians were offered directly by the health plans to the rates that NTSP had succeeded in obtaining from those health plans, and concluded that: NTSP's contract rates with Aetna were at least 15 percent higher for both HMO and PPO arrangements; its contract rates with Cigna were at least 12 percent higher for HMO arrangements and 20 percent higher for PPO arrangements; and its contract rates with United were 15 percent higher for HMO arrangements. CCPTB at 21-22. However, the evidence cited by Complaint Counsel does not support these conclusions.

(iii) Procompetitive justifications

Respondent asserts that its conduct and business model have strong procompetitive effects and efficiencies, for both risk and non-risk contracts. The evidence presented at trial demonstrates that, with respect to non-risk contracts, NTSP's business model does not generate strong efficiencies, and that any efficiencies generated from NTSP's risk contract business do not, to a significant degree, spillover into NTSP's non-risk contract business. The evidence further establishes that any efficiencies that NTSP has achieved from its risk contract business that may spillover to NTSP's non-risk contract business are not dependent upon and do not require NTSP's negotiation of economic terms in non-risk contracts.

NTSP is not clinically integrated for patients under NTSP's non-risk contracts. F. 246. For patients covered under NTSP's non-risk contracts, NTSP does not: engage in case management;

provide feedback to physicians concerning patient care; require adherence to its clinical guidelines and protocols; operate or refer patients to any disease management programs or patient registries; or engage in meaningful patient education. F. 365, 370, 372-73, 375. NTSP's medical director has no responsibility for controlling costs for patients under NTSP's non-risk contracts and NTSP's medical management committee does not evaluate the care of patients under NTSP's non-risk contracts. F. 366-67. NTSP's hospital utilization management program does not apply to patients under NTSP's non-risk contracts and NTSP's information systems do not include data for patients under NTSP's non-risk contracts. F. 368-69.

Sixty percent of NTSP's physicians participate in non-risk contacts. Roughly half of those physicians participate in risk-sharing contracts. F. 51. NTSP physicians who do not participate in NTSP's shared risk contract are unlikely to learn and apply techniques to control costs and to improve quality that are developed or learned in the context of that risk-sharing arrangement. F. 379. Further, NTSP has not achieved significant spillover benefits from its risk business to its non-risk business because it lacks data for patients seen under non-risk contracts and thus is hindered in implementing organized processes for these patients. F. 378. Finally, NTSP does not need to set minimum contract rates in its non-risk contracts in order for any efficiencies achieved through NTSP's risk contract business to spillover to NTSP's non-risk contract business. F. 380.

b. Summary of parties' positions

Complaint Counsel asserts that because NTSP's acts and practices fit squarely within the conduct traditionally condemned as *per se* illegal, there is no need to engage in an extensive or elaborate analysis of market definition and competitive effects. CCPTB at 60. Complaint Counsel further asserts that irrespective of the standard of analysis applied, indirect evidence of Respondent's market power is unnecessary where there is direct evidence of price fixing among competitors. CCPTB at 60.

Respondent asserts that the rule of reason analysis should be applied in this case since the conduct at issue might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition. RPTB at 4. Respondent further asserts that because Complaint Counsel has not demonstrated that the challenged conduct has a net anticompetitive effect and has not proven NTSP's market power, Complaint Counsel has not proven an unreasonable restraint of trade. RPTB at 9, 11.

c. Analysis

Section 1 of the Sherman Act provides that "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1. Despite its broad language, Section 1 has long been interpreted to outlaw only those restraints that are "unreasonable." *Maricopa*, 457 U.S. at 343. The Supreme Court has set forth three methods for

analyzing the reasonableness of a restraint on trade: (1) *per se* analysis, for obviously anticompetitive restraints; (2) quick look analysis, for those with some procompetitive justification; and (3) the full "rule of reason," analysis for restraints whose net impact on competition is particularly difficult to determine. *Continental Airlines, Inc. v. United Airlines, Inc.*, 277 F.3d 499, 508-09 (4th Cir. 2002). In California Dental, the Supreme Court held, as demonstrated by the circumstances before it, "there is generally no categorical line to be drawn between restraints that give rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment." *Id.* at 780-81. Instead, what is required is to look to "the circumstances, details, and logic of a restraint." *Id.* at 781. The three methods are best viewed as a continuum, on which the "amount and range of information needed" to evaluate a restraint varies, depending on how "highly suspicious" and how "unique" the restraint is. *Continental Airlines*, 277 F.3d at 509 (citing 11 Herbert Hovenkamp, Antitrust Law P 191 la (1998); *California Dental*, 526 U.S. at 779-81) .

In *California Dental*, the challenged restraint of trade —restrictions on both discount and nondiscount advertising — "fail[ed] to present a situation in which the likelihood of anticompetitive effects [was] comparably obvious." *Id.* at 771. The Supreme Court held that, where competing claims about the effects of the professional advertising restrictions were plausible, the obvious anticompetitive effect that triggers abbreviated analysis had not been shown. *Id.* at 778. Thus, the Supreme Court remanded the case for a more thorough inquiry into the consequence of the

challenged restraints. *Id.* at 759, 781. However, where the effects of an agreement are "intuitively obvious" and "easily ascertained," *California Dental*, 526 U.S. at 759, 770, no elaborate study of the industry is needed to establish the illegality of the agreement. *Dagher v. Saudi Refining Inc.*, 30 F.3d 1108, 1116 (9th Cir. 2004).

Agreements among competitors to fix or set prices have been historically condemned as *per se* illegal. *Socony-Vacuum*, 310 U.S. at 218; *Maricopa*, 457 U.S. at 344 ("The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some."); *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 647 (1980) ("It has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable.") (citations omitted); *Nat'l Soc'y of Profl Engineers v. United States*, 435 U.S. 679, 692 (1978) (noting that "price is the 'central nervous system of the economy'" and holding that "an agreement that 'interferes with the setting of price by free market forces' is illegal on its face") (citation and alteration omitted).

Courts, after *California Dental*, have applied the *per se* analysis to horizontal price fixing. *E.g.*, *Dagher*, 369 F.3d at 1116 n.7 ("Because we hold that the plaintiffs have made a sufficient showing with respect to the illegality of the alliance's price fixing system under the per se rule, we need not decide whether that scheme would survive 'quick look' review."); *Freedom Holdings Inc. v. Spitzer*, 357 F.3d 205, 226 (2nd Cir. 2004); *Freeman v. San Diego Ass'n of Realtors*, 322 F.3d 1133, 1150-54 (9th Cir.

2003). "Traditional 'hard-core' price fixing remains *per se* unlawful under the seminal case *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-24 (1940), and its progeny." *Todd*, 275 F.3d at 198.

Courts employ the quick look approach when a restraint of trade is not illegal *per se*, but nevertheless has such obvious anticompetitive effects that a "full scale" rule of reason analysis is not necessary. *California Dental*, 526 U.S. at 770. "[W]hen there is an agreement not to compete in terms of price or output, 'no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement.'" *NCAA v. Bd. of Regents*, 468 U.S. 85, 109 (1984).

Regardless of what method of analysis is used, "the criterion to be used in judging the validity of a restraint on trade is its impact on competition." *NCAA*, 468 U.S. at 104. "'Whether the ultimate finding is the product of a presumption or actual market analysis, the essential inquiry remains the same — whether or not the challenged restraint enhances competition.'" *California Dental* (quoting *NCAA*, 468 U.S. at 104). The analytical focus is on what conclusions regarding the competitive impact of a challenged restraint can confidently be drawn from the facts demonstrated by the parties. *See California Dental*, 526 U.S. at 779-81; *NCAA*, 468 U.S. at 103-04.

In *California Dental*, the complaint alleged that an association of dentists had unreasonably restricted two types of advertising: price advertising, particularly discounted fees, and advertising relating to the quality of dental services. 526 U.S. at 762. Here, the challenged restraint is a

horizontal price fixing agreement: an agreement on the minimum reimbursement level that NTSP will accept on behalf of its member physicians for those physicians' services pursuant to non-risk contracts with health insurance payors. Whereas in *California Dental*, the anticompetitive effects of the restrictions on advertising were not obvious, in this case, the effects of agreements to set minimum price levels are "intuitively obvious." Thus, no elaborate study of the industry is needed to establish the illegality of NTSP's actions. *See California Dental*, 526 U.S. at 759; *Dagher*, 369 F.3d at 1116.

To the extent that an examination of effects is required, in this case, the effects of NTSP's concerted action have been to cause health insurance payors to increase their offers or agree to better terms of coverage than the payors otherwise would have, but for NTSP's collective actions. Although the evidence is not conclusive that NTSP's actions resulted in supracompetitive prices, such evidence does not defeat a finding of liability in this case. *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 424 (1990) (It "is no excuse that the prices fixed are themselves reasonable.") (citations omitted).

Also, in *California Dental*, the restrictions on advertising, at least on their face, were designed to avoid false or deceptive advertising and thus "might plausibly be thought to have a net procompetitive effect, or possibly no effect at all on competition." 526 U.S. at 771. Respondent asserts that NTSP's conduct might plausibly be thought to have a net procompetitive effect because NTSP's conduct and business model have strong procompetitive effects and efficiencies. RPTB at 1. Where a defendant

asserts that the challenged conduct has procompetitive effects, the defendant bears the burden of establishing those procompetitive effects. *California Dental*, 526 U.S. 775 n.12. Courts evaluate whether claimed efficiencies are plausible, *NCAA*, 468 U.S. at 114; *Maricopa*, 457 U.S. at 353, and whether the challenged conduct is reasonably necessary to achieve the legitimate objective identified by a defendant. *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 19-21 (1979); *United States v. Brown Univ.*, 5 F.3d 658, 678-79 (3rd Cir. 1993).

In this case, as found in F. 364-80, and summarized above, there is no plausible and valid efficiency justification for collectively setting the prices in non-risk contracts, nor is such conduct reasonably necessary to achieve the claimed procompetitive benefits. Because the challenged restraint of trade does not have a net procompetitive effect on competition, a more thorough inquiry into the consequences of the challenged restraints is not necessary. *See California Dental*, 526 U.S. at 759, 781.

Complaint Counsel has demonstrated that the actions taken by NTSP to coerce health insurance payors to increase their offers of rate reimbursement or offer more favorable economic terms to NTSP's physicians constitute an unreasonable restraint of trade in violation of Section 1 of the Sherman Act and Section 5 of the FTC Act.

E. Remedy

1. Standards

Pursuant to Section 5 of the Federal Trade Commission Act, upon determination that the challenged practice is an unfair method of competition, the Commission "shall issue . . . an order requiring such . . . corporation to cease and desist from using such method of competition or such act or practice." 15 U.S.C. § 45(b); *FTC v. Nat'l Lead Co.*, 352 U.S. 419, 428 (1957) (Commission is authorized "to enter an order requiring the offender to 'cease and desist' from using such unfair method."). The remedy selected must have a "reasonable relation to the unlawful practices found to exist." *Nat'l Lead Co.*, 352 U.S. at 428.

In this case, Complaint Counsel has proven that Respondent engaged in horizontal price fixing through its negotiation, on behalf of its member physicians, of economic terms of non-risk contracts with health plan payors for the provision of physician services. The remedy necessary to bring an end to this unfair method of competition is an order requiring Respondent to cease and desist from collective price fixing in its negotiation of non-risk contracts. In addition, to the extent that there are any existing, current non-risk contracts between NTSP, negotiated on behalf of its member physicians, and any health care payor, Respondent must take actions, as set forth in the Order, to allow termination of any such existing contracts.

2. Provisions

Complaint Counsel's proposed order seeks a provision requiring Respondent to cease and desist from entering into an agreement among physicians "to deal, refuse to deal, or threaten to refuse to deal with any payor" and "not to deal individually with

any payor, or not to deal with any payor through any arrangement other than Respondent." Complaint Counsel's Proposed Order, Sections II.A.2, 4. Complaint Counsel explains that this provision is "intentionally broad so as to preclude respondents from engaging both in the precise conduct found unlawful in this action and 'like and related' conduct." CCPTB at 77. *See also* Complaint Counsel's Opening Statement, Tr. at 60 (Complaint Counsel seeks an order "broadly requiring NTSP to messenger contracts.").

This broad request could have the effect of compelling Respondent to messenger contracts or become a party to contracts sent to it by payors, regardless of potential risks to Respondent, its member physicians, and its patients. A mandatory injunction, which compels a party to act, is an extraordinary remedy that should be granted only in compelling circumstances. *Citizens Concerned for Separation of Church and State v. City and County of Denver*, 628 F.2d 1289, 1299 (10th Cir. 1980); *Justin Indus., Inc. v. Choctaw Sec.*, LP., 747 F. Supp. 1218, 1220 (N.D. Tex. 1990), *aff'd*, 920 F.2d 262 (5th Cir. 1990). Sufficient compelling circumstances have not been demonstrated in this case.

Moreover, Complaint Counsel's authority cited in support of its proposed relief is based only on consent decrees. CCPTB at 76. "[T]he circumstances surrounding . . . negotiated [consent decrees] are so different that they cannot be persuasively cited in a litigation context." *United States v. E.I. du Pont de Nemours*, 366 U.S. 316, 330 n.12 (1961). Sections II.A.2 and 4 of Complaint Counsel's Proposed Order, which are not narrowly

tailored to remedy the violation of law found to exist, are broader than required to remedy the unlawful conduct. A provision that could require Respondent to messenger all contracts or become a party to contracts sent to it by payors will not be ordered. Such overreaching is unnecessary. Accordingly, Sections II.A.2, 4 of Complaint Counsel's proposed order are not ordered.

In addition, any remedy must not contravene Texas health care laws, other Texas law, or federal law. *E.g.*, 28 TEX. ADMIN. CODE § 3.3703 (laying out contracting requirements for PPOs concerning exclusivity, savings inducements, hold-harmless clauses, prompt payment, continuity of care, disclosure of opinions to patients, disclosure of economic profiling criteria, disclosure of quality assessment criteria, and termination); 29 TEX. ADMIN. CODE § 21.2817 (relating to clean claims and prompt payment); TEX. INS. CODE art. 3.70-3C (same issues as TEX. ADMIN. CODE § 3.3703). The Supreme Court recently limited an agency's remedies to those that did not conflict with other laws, statutes, and policies unrelated to the agency. *Hoffman Plastic Compounds, Inc. v. NLRB*, 535 U.S. 137, 144-45 (2002). The Order issued herewith provides that nothing in this Order shall require NTSP violate state or federal law. Further, the Order is narrowly tailored and reasonably related to the violation of law found to exist.

3. Duration

Complaint Counsel has requested that the order issued in this case remain in effect for a period of twenty years. CCPTB at 79. Pursuant to the Policy Statement Regarding Duration of Competition

and Consumer Protection Orders, 60 Fed. Reg. 42,569 (August 16, 1995), the Commission's stated policy is for administrative cease and desist orders to terminate after twenty years. The Order entered in this case shall remain in effect for a period of twenty years.

IV. SUMMARY OF CONCLUSIONS OF LAW

1. Respondent North Texas Specialty Physicians ("NTSP") is a corporation, as "corporation" is defined by Section 4 of the Federal Trade Commission Act, ("FTC Act"); 15 U.S.C. § 44.

2. The participating physicians of NTSP are "members" of NTSP, as that term is used in the definition of "corporation" in Section 4 of the FTC Act, 15 U.S.C. § 44.

3. The jurisdiction of the Federal Trade Commission ("FTC") extends to non-profit entities when a substantial part of the entity's total activities provides economic benefits for its members.

4. A substantial part of Respondent's activities provides economic benefits for its members.

5. The acts and practices charged in the Complaint are in or affect commerce, as "commerce" is defined in Section 4 of the FTC Act, 15 U.S.C. § 44.

6. The Federal Trade Commission has jurisdiction over Respondent and over the subject matter of this proceeding, pursuant to Section 5 of the FTC Act, 15 U.S.C. § 45.

7. The relevant market is physician services available to patients in the Fort Worth, Texas area.

8. Complaint Counsel has met its burden of proof of demonstrating that Respondent engaged in an agreement in restraint of trade.

9. Respondent has engaged in a contract, combination, or conspiracy to fix prices in non-risk contracts to be charged by physicians for providing medical services to health plans' patients.

10. Respondent's contract, combination, or conspiracy unreasonably restrained trade.

11. Respondent has not met its burden of proof of demonstrating that the challenged conduct has a net procompetitive effect on competition.

12. Respondent's fixing prices in non-risk contracts does not have a plausible and valid efficiency justification.

13. Respondent's fixing prices in non-risk contracts is not reasonably necessary to create any efficiencies.

14. The acts and practices of Respondent, as set forth in paragraphs 9 and 10 above, constitute unfair methods of competition in violation of Section 5 of the FTC Act, 45 U.S.C. § 45.

15. Relief designed to remedy Respondent's unlawful activities and to require Respondent to cease and desist from collective price fixing is appropriate.

16. The Order entered herein is necessary and appropriate to remedy the violation of law found to exist.

ORDER

I.

IT IS ORDERED that, as used in this Order, the following definitions shall apply:

A. "Respondent" means North Texas Specialty Physicians ("NTSP"), its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by North Texas Specialty Physicians, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.

B. "Medical group practice" means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, members, or employees, or in which only one physician practices medicine.

C. "Participate" in an entity means: (1) to be a partner, shareholder, owner, member, or employee of such entity; or (2) to provide services, agree to provide services, or offer to provide services, to a payor through such entity. This definition also applies to all tenses and forms of the word "participate," including, but not limited to, "participating," "participated," and "participation."

D. "Payor" means any person that pays, or arranges for the payment, for all or any part of any physician services for itself or for any other person. Payor includes any person that

E. "Person" means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.

F. "Physician" means a doctor of allopathic medicine ("M.D.") or a doctor of osteopathic medicine ("D.O.").

G. "Preexisting contract" means a contract that was in effect on the date of receipt by a payor that is a party to such contract of notice sent by Respondent, pursuant to Paragraph IV.A.3 of this Order, of such payor's right to terminate such contract.

H. "Principal address" means either (1) primary business address, if there is a business address, or (2) primary residential address, if there is no business address.

I. "Qualified clinically-integrated joint arrangement" means an arrangement to provide physician services in which:

1. all physicians that participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the physicians who participate in the arrangement, in order to control

costs and ensure the quality of services provided through the arrangement; and

2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

J. "Qualified risk-sharing joint arrangement" means an arrangement to provide physician services in which:

1. all physicians who participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the physicians who participate jointly to control costs and improve quality by managing the provision of physician services, such as risk-sharing involving:

a. the provision of physician services for a fixed amount per patient, per month paid by payors;

b. the provision of physician services for a predetermined percentage of premium or revenue from payors;

c. the use of significant financial incentives for physicians who participate to achieve, as a group,

specified cost-containment goals; or

d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; and

2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies rough the joint arrangement.

II.

IT IS FURTHER ORDERED that Respondent, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

A. Entering into, adhering to, participating in, maintaining, organizing, implementing,

enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians to negotiate on behalf of any physician with any payor, regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms;

B. Exchanging or facilitating in any manner the exchange or transfer of information among physicians concerning the terms or conditions, including price terms, on which any physician is willing to deal with a payor;

C. Attempting to engage in any action prohibited by Paragraph II.A or II.B, above; and

D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through 11.C above.

PROVIDED, HOWEVER, that nothing in this Order shall prohibit any agreement involving or conduct by Respondent that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or qualified clinically- integrated joint arrangement.

PROVIDED, FURTHER, HER, that nothing contained in this Order shall prohibit Respondent from communicating purely factual information describing the terms and conditions of any payor

offer, including objective comparisons with terms offered by other payors, or from expressing views relevant to various health plans. "Objective information" or "objective comparison" constitutes empirical data that is capable of being verified or a comparison of such data.

PROVIDED, FURTHER, that nothing contained in this Order shall require Respondent to violate state or federal law.

III.

IT IS FURTHER ORDERED that, for three (3) years from the date this Order becomes final, Respondent shall notify the Secretary of the Commission in writing ("Notification") at least sixty (60) days prior to entering into any arrangement with any physician under which Respondent would act as a messenger, or as an agent on behalf of the physician, with payors regarding contracts.

The Notification shall include the identity of each proposed physician participant; the proposed geographic area in which the proposed arrangement will operate; a copy of any proposed physician participation agreement; a description of the proposed arrangement's purpose and function; a description of any resulting efficiencies expected to be obtained through the arrangement; and a description of procedures to be implemented to limit possible anticompetitive effects, such as those prohibited by this Order.

Notification is not required for Respondent's subsequent acts as a messenger pursuant to an

arrangement for which this Notification has been given.

Receipt by the Commission from Respondent of any Notification, pursuant to this Paragraph III, is not to be construed as a determination by the Commission that any action described in such Notification does or does not violate this Order or any law enforced by the Commission.

IV.

IT IS FURTHER ORDERED that Respondent shall.

A. Within thirty (30) days after the date on which this Order becomes final, send by first-class mail, return receipt requested, a copy of this Order to:

1. each physician who participates, or has participated, in Respondent since January 1, 2000;

2. each officer, director, manager, and employee of Respondent; and

3. the chief executive officer of each payor with which Respondent has a record of having been in contact since January 1, 2000, regarding contracting for the provision of physician services.

B. Terminate, without penalty or charge, and in compliance with any applicable laws, any preexisting contract with any payor for the

provision of physician services, pursuant to a fee-for-service agreement at the earlier of

1. receipt by Respondent of a written request from a payor to terminate such contract; or

2. the earliest termination or renewal date (including any automatic renewal date) of such contract.

Provided, however, a preexisting contract may extend beyond any such termination or renewal date no later than one (1) year after the date on which the Order becomes final, if prior to such termination or renewal date, (a) the payor submits to Respondent a written request to extend such contract to a specific date no later than one (1) year after the date this Order becomes final, and (b) Respondent has determined not to exercise any right to terminate; *provided further*, that any payor making such request to extend a contract retains the right, pursuant to Paragraph IV.B.1 of this Order, to terminate the contract at any time.

C. Within ten (10) days after receiving a written request from a payor, pursuant to Paragraph IV.B.1 of this Order, distribute, by first-class mail, return receipt requested, a copy of that request to each physician participating in Respondent as of the date Respondent receives such request.

D. For a period of three (3) years after the date this Order becomes final:

1. distribute by first-class mail, return receipt requested, a copy of this Order to:

a. each physician who begins participating in Respondent, and who did not previously receive a copy of this Order from Respondent, within thirty (30) days of the time that such participation begins;

b. each payor who contracts with Respondent for the provision of physician services, and who did not previously receive a copy of this Order from Respondent, within thirty (30) days of the time that such payor enters into such contract;

c. each person who becomes an officer, director, manager, or employee of Respondent and who did not previously receive a copy of this Order from Respondent, within thirty (30) days of the time that he or she assumes such responsibility with Respondent;

2. annually publish a copy of this Order in an official annual report or newsletter sent to all physicians who participate in Respondent, with such prominence as is given to regularly featured articles.

E. File a verified written report within sixty (60) days after the date this Order becomes final,

and annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each such report shall include:

1. a detailed description of the manner and form in which Respondent has complied and is complying with this Order; and

2. copies of the return receipts required by Paragraphs IV.A, IV.C, and IV.D of this Order.

F. Notify the Commission at least thirty (30) days prior to any proposed change in Respondent, such as dissolution, assignment, sale resulting in the emergence of a successor company or corporation, the creation or dissolution of subsidiaries, or any other change in Respondent that may affect compliance obligations arising out of this Order.

V.

IT IS FURTHER ORDERED that Respondent shall notify the Commission of any change in its principal address within twenty (20) days of such change in address.

VI.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with

this Order, Respondent shall permit any duly authorized representative of the Commission:

A. Upon written request and two (2) days' notice to Respondent, access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in its possession, or under its control, relating to any matter contained in this Order; and

B. Upon written request and five (5) days' notice to Respondent, and in the presence of counsel, and without restraint or interference from it, to interview Respondent or employees of Respondent, relating to any matter contained in this Order.

VII.

IT IS FURTHER ORDERED that this Order shall terminate twenty (20) years from the date it is issued.

ORDERED:

D. Michael Chappell
Administrative Law Judge

Date: November 15, 2004

Supreme Court, U.S.
FILED
JAN 14 2009
OFFICE OF THE CLERK

No. 08-515

In the Supreme Court of the United States

NORTH TEXAS SPECIALTY PHYSICIANS, PETITIONER

v.

FEDERAL TRADE COMMISSION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE FEDERAL TRADE COMMISSION IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly affirmed the Federal Trade Commission's decision that activities of an association composed of and controlled by competing physicians constituted unlawful horizontal price fixing in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A3-A52) is reported at 528 F.3d 346. The opinion of the Federal Trade Commission (Pet. App. A53-A130) is reported at 140 F.T.C. 715.[1] The initial decision of the administrative law judge (Pet. App. A131-A297) is reported at 140 F.T.C. 805.

JURISDICTION

The judgment of the court of appeals was entered on May 14, 2008. A petition for rehearing was denied on

[1] Some electronic databases may have an earlier version of the Commission's opinion. The correct verison of the Commission's opinion, as modified, is available on its website at http://ftc.gov/os/adjpro/d9312/051201opinion.pdf.

July 18, 2008 (Pet. App. A1-A2). The petition for a writ of certiorari was filed on October 16, 2008. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

In September 2003, the Federal Trade Commission (Commission or FTC) issued an administrative complaint against petitioner. The complaint alleged that petitioner had restrained competition among its physicians in violation of Section 5 of the Federal Trade Commission Act (FTC Act), 15 U.S.C. 45, by, *inter alia*, orchestrating price competition among its member physicians, negotiating price terms in payor contracts on behalf of its member physicians, and refusing to deal with payors except on collectively agreed-upon terms. After an administrative trial, an administrative law judge (ALJ) ruled that petitioner had engaged in unlawful horizontal price fixing. The Commission, reviewing *de novo*, affirmed. The court of appeals affirmed the FTC's decision that petitioner's conduct constituted horizontal price fixing not plausibly related to any procompetitive efficiencies, but remanded to the Commission to reconsider its remedial order. Pet. App. A3-A52.

1. Petitioner is an association of independent, competing physicians and physician groups, predominantly specialists, who practice in and around Fort Worth, Texas. Pet. App. A4. Its size has ranged from approximately 480 to 650 participating physicians. *Id.* at A4, A146. In Tarrant County, which includes the city of Fort Worth, petitioner's member physicians make up a substantial percentage of practitioners in certain medical specialties, including 80% in pulmonary disease, 69% in urology, and 59% in cardiovascular disease. *Id.* at A4-A5.

Petitioner is controlled by its member physicians, who elect representatives from among their ranks to serve on its eight-member Board of Directors. It was founded in 1995 by a group of doctors principally for the purpose of negotiating risk-sharing (risk) contracts with payors, including insurance companies and health plans. Risk contracts typically pay a group of physicians a fixed fee per patient, regardless of the quantity of services provided, and the physicians share the risk of profit and loss based on how efficiently they provide medical care to those patients. Payors' interest in risk contracts declined, however, and petitioner's focus shifted to assisting its members in negotiating non-risk-sharing (non-risk) contracts, which typically reimburse physicians on a fee-for-service basis. At the time of the administrative trial in this case, petitioner had only one risk contract and 20 non-risk contracts, and half of petitioner's members did not participate in its risk contract. Pet. App. A5.

Only petitioner's activities with respect to non-risk contracts are at issue in this case. Pet. App. A5. In this context, petitioner does not provide medical services, assemble teams of physicians, or employ any of the utilization management programs that it employs under its risk contract. Rather, its activities in question are directed solely at coordinating the contractual arrangements between the member physicians who provide services and the persons who pay for them. *Id.* at A225-A227.

Petitioner's physician members enter into a Physician Participation Agreement (PPA). The PPA grants petitioner the right to receive all payor offers and imposes on the physicians a duty to forward to petitioner all payor offers they receive. Under the terms of the

PPA, the member physicians agree that they will not independently pursue a payor offer unless and until petitioner notifies them that it has permanently discontinued negotiations with the payor. Petitioner establishes minimum rates for its physicians' services by conducting an annual poll of its membership, asking the physicians to indicate the minimum reimbursement rates that they would accept. Petitioner calculates the averages of the indicated rates and reports those averages back to its physicians as the minimum rates that petitioner will use when negotiating with payors on their behalf. Pet. App. A6-A7.

2. The Commission issued an administrative complaint alleging that petitioner, acting as a combination of competing physicians, had unreasonably restrained competition in the provision of physician services in the Fort Worth area. The FTC's complaint alleged that petitioner had orchestrated price coordination among its member physicians, had negotiated price terms in payor contracts for those physicians, had refused to submit payor offers to its member physicians unless petitioner's price terms had been met, and had refused or threatened to refuse to deal with payors except on collectively agreed-upon terms. Pet. App. A134-A135. The complaint alleged that those practices constituted unfair methods of competition in violation of Section 5 of the FTC Act. *Id.* at A135.

After a full administrative trial at which nearly 1500 exhibits were admitted and 17 witnesses testified (Pet. App. A136), the ALJ issued an initial decision containing findings of fact and conclusions of law. *Id.* at A131-A297. The ALJ concluded that petitioner's challenged conduct constituted unlawful horizontal price fixing,

unrelated to any procompetitive justifications. *Id.* at A285.

3. After conducting a *de novo* review of the facts, the Commission affirmed the decision of the ALJ. Pet. App. A53-A130. The Commission adopted the ALJ's findings of fact, *id.* at A56, and found that petitioner's conduct constituted a restraint of trade in violation of Section 1 of the Sherman Act, 15 U.S.C. 1. Pet. App. A67 n.10; see generally *FTC* v. *Cement Inst.*, 333 U.S. 683, 689-693 (1948) (holding that Sherman Act violations may be redressed as violations of Section 5 of the FTC Act). The Commission determined that petitioner "was able to orchestrate price agreements among its physicians" through a variety of mechanisms. Pet. App. A129. Those mechanisms included the PPA, which grants petitioner a right of first negotiation with payors (*id.* at A90-A92); petitioner's annual polling of its physicians to establish minimum reimbursement rates for its negotiations with payors, and its communication of those minimum rates back to its physicians (*id.* at A84-A89); petitioner's use of powers of attorney obtained from its physicians (*id.* at A92-A93); and petitioner's termination of, and threats to terminate, its members' participation in a health plan to secure payors' agreement to petitioner's minimum rates (*id.* at A94-A97).

The Commission first examined whether petitioner's operations involved an "agreement" between independent actors. Pet. App. A67, A79-A84. The Commission held that such an agreement existed, based on long-standing precedents holding that an action nominally taken by a single entity may be regarded for antitrust purposes as the product of agreement when the entity is controlled by a group of competitors and serves as the agent for those competitors. *Id.* at A79-A80. The Com-

mission rejected petitioner's argument that there could be no finding of collective action absent a showing of direct agreement between the physicians on price. *Id.* at A82-A83. "[I]t is enough," the Commission held, "that participating physicians authorized [petitioner] to take certain actions on their behalf, knowing that other members were doing the same thing." *Id.* at A83.

The Commission observed that petitioner's conduct was substantially similar to conduct that this Court condemned as per se unlawful price fixing in *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982). Pet. App. A69-A70. Nonetheless, the Commission declined to apply the per se rule here, explaining that this Court has urged caution in the application of the per se label to conduct in a professional setting, and that the Commission wishes to encourage efficiency-enhancing collaborative activity among heath-care providers. *Id.* at A71-A73. The FTC further emphasized that it would consider any proffered justifications for petitioner's conduct. *Id.* at A73. The Commission accordingly analyzed the challenged conduct under an abbreviated rule of reason analysis, following the guidance provided by this Court in *California Dental Ass'n* v. *FTC*, 526 U.S. 756 (1999). Pet. App. A67-A77, A101-A104.

The Commission analyzed the competitive impact of petitioner's activities and found that petitioner's conduct was highly likely, absent countervailing procompetitive efficiencies, to suppress competition. Pet. App. A101. The Commission found that petitioner's practices enabled it "to collectively set prices and present its physicians as a unified and strong force within Fort Worth," thereby "reduc[ing] the risk that payors would be able to contract around [petitioner]." *Id.* at A102. The Commission further found that because petitioner's members

constitute a large percentage of physicians in key specialties in Fort Worth, petitioner's practices hindered the ability of payors to assemble a marketable physician network in the Fort Worth area without bargaining with petitioner, and made payors "more willing to pay [petitioner's member] physicians' consensus price because of the threat to their physician networks." *Ibid.*

The Commission next considered whether petitioner had advanced a plausible procompetitive justification for its conduct that would warrant a more searching examination of competitive effects. After careful consideration of each of petitioner's proffered justifications, the Commission concluded that petitioner had "failed to articulate any logical nexus" between its challenged activities and the claimed efficiencies, and that petitioner's proffered justifications were contradicted by the record. Pet. App. A104-A112.

The Commission found, *inter alia*, that petitioner's principal justification—that its polling and its establishment of minimum rates served to promote "spillover" benefits from its risk contract by identifying which non-risk offers would be of interest to a majority of its risk panel physicians—was undermined by the fact that petitioner polled all of its members, risk and non-risk alike, and did not distinguish between the prices indicated by its risk and non-risk member physicians. Pet. App. A106. The Commission also noted that petitioner had offered no explanation as to "how [member] physicians who only enter into non-risk contracts could achieve spillover efficiencies from [petitioner's] single risk contract"—"a non-trivial point, because non-risk physicians make up half of [petitioner's] members." *Id.* at A108. Because petitioner had failed to articulate any plausible justification for its inherently suspect activities, the

Commission concluded that its conduct could be condemned without further analysis of competitive effects, such as proof of a relevant market and market power. *Id.* at A118-A121.

Having found that petitioner's activities violated Section 5 of the FTC Act, the Commission entered a cease and desist order that prohibits petitioner from engaging in the type of conduct found to be unlawful. Pet. App. A121-A129.

4. The court of appeals affirmed. Pet. App. A3-A52. The court agreed with the Commission that "[petitioner's] participating physicians have taken collective action to obtain higher fees from payors." *Id.* at A13. The court observed that "[w]hen an organization is controlled by a group of competitors, it is considered to be a conspiracy of its members." *Id.* at A15 (citing *United States* v. *Sealy, Inc.* 388 U.S. 350, 352-354 (1967)). The court agreed with the Commission that collective action could occur without direct communication among the member physicians. *Id.* at A16.

Like the Commission, the court of appeals declined to "decide whether [petitioner's] challenged practices constituted a per se violation" of the antitrust laws. Pet. App. A28. The court agreed with the FTC, however, that petitioner's challenged practices "bear a very close resemblance to horizontal price-fixing, generally deemed a per se violation." *Ibid.* The court reviewed the Commission's abbreviated rule of reason analysis and found that the FTC's "articulation of the shifting burdens" comported with the framework established in *California Dental* and in other decisions of this Court. *Id.* at A26. The court held that "a quick-look analysis was appropriate in this case" because "the net anticom-

petitive effects of certain of [petitioner's] practices were obvious." *Id.* at A29.

The court of appeals upheld, as "logical and supported by the record," the Commission's finding that petitioner's challenged practices "foreclosed or delayed" payor negotiations with physicians who otherwise would have been willing to accept a fee lower than the minimum rates established by petitioner. Pet. App. A31-A32. The court also agreed with the Commission that "proof of higher fees for [petitioner's member] physicians is not necessary" to establish an antitrust violation. *Id.* at A40. The court explained that, "if a practice 'is likely enough to disrupt the proper functioning of the price-setting mechanism of the market . . . it may be condemned even absent proof that it resulted in higher prices.'" *Ibid.* (quoting *FTC* v. *Indiana Fed'n of Dentists*, 476 U.S. 447, 461-462 (1986)).

While acknowledging that petitioner's claim of "spillover benefits" had "some facial plausibility," the court of appeals found that "closer examination of the underpinnings of the justification reveals significant gaps in logic." Pet. App. A41. The court explained in particular that petitioner had failed to "address how [its] nebulous 'teamwork' efficiencies are dependent on its price-fixing activities." *Id.* at A44 (brackets in original). The court concluded that petitioner had not shown that its activities "might plausibly be thought to have a net procompetitive effect, or possibly no effect on competition." *Id.* at A46-A47 (quoting *California Dental*, 526 U.S. at 781).

The court of appeals concluded that "'the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency' of [petitioner's] challenged practices follows from the 'look' the FTC conducted in this case, even though that

'look' was less than a fullblown market analysis." Pet. App. A46 (quoting *California Dental*, 526 U.S. at 781). The court accordingly affirmed, as "supported by the law and substantial evidence," the FTC's determination that petitioner's activities, "taken as a whole, amounted to horizontal price-fixing that is unrelated to procompetitive efficiencies." *Id.* at A47. The court held, however, that one provision of the FTC's remedial order was "overly broad and internally inconsistent," *id.* at A50, and it remanded the case to the Commission for modification of that provision, see *id.* at A52.

ARGUMENT

The court of appeals' decision is correct and does not conflict with any decision of this Court or of any other court of appeals. Further review is not warranted.

1. Petitioner argues (Pet. 20) that the court of appeals' decision "equate[s] to a ruling that [petitioner] violated Section 1 of the Sherman Act by encouraging or attempting collusion." That contention is incorrect. Neither the Commission nor the court of appeals based its liability determination on a finding of encouraged or attempted collusion. Rather, both the FTC and the court of appeals found that collective action had occurred because the member physicians agreed, as a term of their participation in petitioner, to use petitioner as their agent to negotiate with payors on behalf of the overall membership in order to obtain a collectively-determined minimum price. Pet. App. A16-A17, A31-A34, A58, A79-A84. That agreement was carried out through actual payor negotiations; through the member physicians' execution of powers of attorney designating petitioner as their bargaining agent; through the physicians' subsequent refusals to deal individually with payors; and

through petitioner's actual and threatened termination of payor contracts to secure payors' agreement to petitioner's poll-derived minimum rates. *Id.* at A34, A38-A39, A85-A97.

Petitioner does not directly challenge those critical factual findings. Instead, it argues that the court of appeals and the Commission principally relied on the fact that petitioner "conducted a poll as to what rates its participating physicians would accept and then published the averages of those responses." Pet. 3; see Pet. 7, 9, 13. Both the Commission and the court of appeals made clear, however, that their liability determinations were premised on the overarching agreement among petitioner's physicians to coordinate their marketplace behavior. The poll was simply the mechanism by which the physicians shared price information and established a consensus price for negotiations with payors. See Pet. App. A30-A31, A84-A86.[2]

Petitioner further contends (Pet. 22) that the court of appeals necessarily based liability only on petitioner's "'encouragement' of price-fixing collusion" because there was no evidence of direct communications between physicians on price, and no showing that petitioner's conduct actually resulted in prices higher than those that other physician groups received.[3] Both the Com-

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[2] Petitioner also disregards the court of appeals' finding that petitioner's challenged conduct is properly deemed collective action by its competing member physicians because the physicians control petitioner through its board of directors. Pet. App. A14-A15; see, *e.g.*, *Sealy, Inc.*, 388 U.S. at 352-354 (marketing association controlled by competing distributors held to be a horizontal combination).

[3] Petitioner contends (Pet. 9) that the ALJ (and the Commission, which adopted the ALJ's findings of fact) found that petitioner did not receive higher rates than did other physician groups. That is incorrect.

mission and the court of appeals, however, expressly rejected petitioner's argument that the absence of evidence of direct communications among petitioner's member physicians negated the existence of a price-fixing agreement. The court of appeals found that the record supported the Commission's finding of collective action because each member physician, knowing that other members were doing the same thing, designated petitioner as his or her agent to negotiate with payors on price and other material terms for the collective benefit of the membership. Pet. App. A16-A17. That is a finding of actual collective action to restrict price competition, not of mere attempted collusion.

In contending that proof of actual higher prices was required in order to establish the existence of a price-fixing agreement, petitioner conflates two distinct issues. The first is whether an agreement regarding price exists; the second is whether that agreement is anticompetitive. In sustaining the Commission's findings on both those questions, the court of appeals correctly held that proof of higher prices was not required because the challenged conduct was "likely enough to disrupt the proper functioning of the price-setting mechanism of the market." Pet. App. A40 (quoting *Indiana Fed'n of Dentists*, 476 U.S. at 461-462).

As this Court recognized in *NYNEX* v. *Discon*, 525 U.S. 128, 135 (1998), conduct may be anticompetitive if it harms "the competitive process." Petitioner interposed itself into the negotiation of agreements for the provision of its member physicians' services, thereby impeding the buyers' ability to negotiate with individual

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The ALJ found only that there was "insufficient evidence" that the rates negotiated by petitioner were "uniformly higher" than the rates other physician groups obtained. Pet. App. A272.

physicians. Evidence of that conduct established the requisite harm to the competitive process, cf. Pet. App. A102 (Commission explains that "[c]onduct that confers on competitors a collective power over price falls within the classic definition of price fixing."), even without proof that petitioner ultimately negotiated higher prices than non-member physicians received.[4]

2. Petitioner's contention that the court of appeals erred by applying a "quick look" rule of reason analysis likewise rests on its mischaracterization of the decision below as imposing antitrust liability for mere attempt to collude. See Pet. 25 (The Commission and the court "rel[ied] primarily on the hypothetical effects of [petitioner's] board's actions in encouraging physician collusion."); Pet. 26, 27. Neither the Commission nor the court of appeals posited anticompetitive effects from a mere "possibility" of collusion. Instead, the Commission found that competitive harm resulted from actual collec-

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[4] The court of appeals explained that, because petitioner based its minimum fees on the average minimum fees identified by the member physicians who responded to its polls, "it is logical to conclude that the fees to which [petitioner] agreed would be higher than the minimum fees that many of its participating physicians * * * had indicated in their polling responses they were willing to accept." Pet. App. A31. The court also noted with approval the FTC's reliance on an expert's view that "negotiation of a minimum price has the effect of raising the prices that 'low end' physicians would otherwise earn, without reducing the price that 'high end' physicians would receive because the 'high end' physicians could 'opt out'" by declining to contract with a particular payor. *Id.* at A31-A32. Petitioner's activities thus had a natural tendency to cause its member physicians, as a group, to charge higher fees than those physicians would otherwise have charged. As the Commission observed, evidence as to the rates received by *other* physician groups is not particularly revealing because those rates may be associated with higher quality of care or different competitive conditions. *Id.* at A121.

tive action by petitioner's physicians to obtain higher prices from payors, and the court of appeals sustained that finding as reasonable and supported by the evidence.

Thus, the court of appeals explained that petitioner's practices "foreclosed or delayed negotiations between those payors and physicians who were willing to accept a fee lower than the minimum fee determined by [petitioner] and used in its negotiations with payors." Pet. App. A31. The court further observed that petitioner's activities "added significant transaction costs to offers below [petitioner's] minimum" because "[a] payor wishing to achieve a contract below that minimum would have to submit its offer to [petitioner], negotiate with [petitioner], and wait until [petitioner] communicated to physicians that negotiations were unsuccessful, before being able to negotiate with physicians directly." *Id.* at A36. Petitioner's activities also "narrowed patients' choices of physicians," *ibid.*; "erect[ed] barriers between payors and physicians who would otherwise be willing to negotiate directly with those payors," *id.* at A41; and created "obstacles to price communications between payors and physicians," *ibid.* The Commission further explained that its "ultimate conclusions in this case do not stand or fall on [the Commission's] assessment of separate actions" but instead are "predicated on the likely effects of the actions taken together." *Id.* at A84.

3. In light of the court of appeals' determination that petitioner failed to show any plausible procompetitive justifications for its challenged practices, the anticompetitive effects described above fully justify the Commission's condemnation of petitioner's conduct under an abbreviated rule of reason. As this Court explained in *California Dental*, "quick-look analysis carries the day

when the great likelihood of anticompetitive effects can easily be ascertained." 526 U.S. at 770. In that case, the Court held that further analysis of competitive effects was required because, *inter alia*, the defendant association had identified plausible procompetitive justifications for its rules governing its members' advertising. *Id.* at 774-778. Those circumstances are not present here. See Pet. App. A41-A47.

Petitioner contends (Pet. 30-35) that the court of appeals should not have applied a quick look rule of reason analysis without first identifying a relevant market, market power, or actual market effects. Even if petitioner had advanced a procompetitive justification that had any logical connection to the restraints at issue (which it did not), that argument would be unavailing. In *California Dental*, this Court made clear that, even when plausible justifications are advanced, the "fullest" market analysis is not necessarily required. 526 U.S. at 779. Rather, the Court explained, the applicable "categories of analysis of anticompetitive effect are less fixed than terms like '*per se*,' 'quick look,' and 'rule of reason' tend to make them appear." *Ibid.* The Court emphasized that rule of reason analysis should be flexible:

> What is required, rather, is an enquiry meet for the case, looking to the circumstances, details, and logic of a restraint. The object is to see whether the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency of a restriction will follow from a quick (or at least quicker) look, in place of a more sedulous one.

Id. at 781.

As explained above, the Commission and the court of appeals concluded, based on extensive evidence that included expert testimony, payor testimony, and petitioner's own assessment of the impact of its practices, that petitioner's activities constituted a serious restraint on independent price-setting by competitors. "[B]ased on the record in this case," the court of appeals explained that "'the experience of the market has been so clear, or necessarily will be, that a confident conclusion about the principal tendency' of [petitioner's] challenged practices follows from the 'look' the FTC conducted in this case, even though that 'look' was less than a fullblown market analysis." Pet. App. A46 (quoting *California Dental*, 526 U.S. at 781); see *id.* at A85, A88-A89, A93-A94, A97. That analysis is fully consistent with this Court's precedents.

4. Contrary to petitioner's contention (Pet. 29-35), the court of appeals' ruling does not conflict with the Sixth Circuit's decision in *Worldwide Basketball & Sports Tours, Inc.* v. *NCAA*, 388 F.3d 955 (2004), cert. denied, 546 U.S. 813 (2005). The Sixth Circuit did not, as petitioner argues, hold that a quick look analysis always requires extensive market analysis, including defining the relevant market. Rather, the Sixth Circuit recognized that "[w]hat is required * * * is an enquiry meet for the case, looking to the circumstances, details, and logic of a restraint." *Id.* at 960 (quoting *California Dental*, 526 U.S. at 780-781). The court in *Worldwide Basketball* explained that, because the conduct at issue in that case "d[id] not have * * * obvious anticompetitive effects," further analysis of the contours and dynamics of the market was required. *Id.* at 960-961 (internal quotation marks omitted). Here, by contrast, the court of appeals found that petitioner's challenged prac-

tices *did* have "obvious" anticompetitive effects. Pet. App. A29.

5. Petitioner asserts (Pet. 35) that this Court's review is warranted because "this case presents an issue of importance to the health care industry." That contention is based on petitioner's reiteration of its earlier arguments that the court of appeals imposed liability for mere attempted collusion; that the court of appeals' quick look analysis was premised on the theoretical effects of attempted collusion; and that the Fifth Circuit's decision conflicts with the Sixth Circuit's ruling in *Worldwide Basketball*. As explained above, those arguments are without merit.

CONCLUSION

The petition for a writ of certiorari should be denied.

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IN THE
SUPREME COURT OF THE UNITED STATES

NORTH TEXAS SPECIALTY PHYSICIANS,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

REPLY IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

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North Texas Specialty Physicians ("NTSP") respectfully files this reply to the Brief in Opposition filed by the Federal Trade Commission ("Commission") to NTSP's petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

REPLY IN SUPPORT OF PETITION

Although NTSP disputes most of the findings by both the Commission and the court of appeals below, NTSP in its Petition for a Writ of Certiorari focused tightly on three salient points for this Court:

1. The court of appeals, like the Commission, relied in large part on attempted collusion as a basis for the ruling that NTSP violated Section 1 of the Sherman Act;

2. Attempted collusion is not a violation of Section 1 of the Sherman Act, and this Court's decision in *California Dental*, allowing for a quick-look rule of reason analysis, was not intended to make attempted collusion a violation of Section 1 of the Sherman Act; and

3. The decision of the court of appeals is inconsistent with the decision of the Sixth Circuit Court of Appeals in *Worldwide Basketball*, which properly required that "the contours of the market and, where relevant, submarket, are sufficiently well-known or defined to permit the court to ascertain" whether the *California Dental* test of easily-ascertained anticompetitive effects is satisfied.

The Brief for the Federal Trade Commission in Opposition ("Opposition") fails to address any of these points head-on.

The Commission's approach to the first point is to discuss findings other than the numerous ones relying on attempted collusion. The Commission, however, does not dispute that the court of appeals based its finding of a violation of Section 1 of the Sherman Act on NTSP's conduct as a whole. Opposition at 14. Nor does the Commission dispute that the conduct considered included mere encouragement by NTSP; the Commission even cites to such statements in its Opposition. Opposition at 13, n.4 (discussing statements in court of appeals decision that it is "logical to conclude" and there is a "natural tendency" to find anticompetitive effects). The Commission simply fails to address NTSP's recital of the repeated instances of reliance of such conduct raised in NTSP's petition. *See* Petition at pp. 20-21, citing references to "encouragement," "urging," and "theoretical" effects by the court of appeals at App. 27-28, 34-35, and 45.

The Commission does not explain why the court of appeals decision can stand if any substantial basis for the appellate decision is attempted collusion. After acknowledging the attempted collusion portions of the analysis, the Commission merely discusses other aspects of the court of appeals decision as support for the outcome.[1] But NTSP's

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[1] Those other aspects were hotly-contested by NTSP, but in the end were admitted by the Commission and its expert not to have had any impact on physician prices or output. *See* Petition at pp. 8-9.

point was never that the "only" basis for the court of appeals decision is attempted collusion—the point is that attempted collusion is at least a *part*, indeed a substantial part, of the basis for the decision. By reaching a decision based on conduct "as a whole" and relying in part on attempted collusion and the hypothetical effects of attempted collusion, the court of appeals decision is in error and should be reversed. As this Court has ruled, "an order may not stand if the agency has misconceived the law." *SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943); *accord Fed. Election Comm'n v. Akins*, 524 U.S. 11, 25 (U.S. 1998) ("If a reviewing court agrees that the agency misinterpreted the law, it will set aside the agency's action and remand the case-even though the agency (like a new jury after a mistrial) might later, in the exercise of its lawful discretion, reach the same result for a different reason."). The same is true for a court of appeals.

The Commission fails to concede the second point that attempted collusion cannot be a violation of Section 1 of the Sherman Act and that the Court in *California Dental* did not intend to create a violation for attempted collusion. The Commission's position seems to be that attempts to collude are "obvious anticompetitive effects" that can be used to support a violation under a quick-look analysis. The Commission fails to address NTSP's argument that "anticompetitive effects" as used in *California Dental* properly should be restricted to actual restraints of price or output by the physicians, rather than a hypothetical postulation of how price or output would have been affected if the physicians had in fact colluded. The Commission's failure to acknowledge these incorrect applications of the law

by the court of appeals strongly supports the need for this Court to clarify that attempted collusion cannot excuse a litigant's failure to make a proper rule of reason showing under *California Dental*.

Third, the Commission attempts to ignore the conflicting decision of the Sixth Circuit in *Worldwide Basketball* by stating that an extensive market analysis is not necessary for a quick-look analysis. The Commission again misses the point. The Sixth Circuit held that anticompetitive effects cannot be "easily ascertained" under the *California Dental* test without "the contours of the market and, where relevant, submarket" being "sufficiently well-known or defined" to make that conclusion. 388 F.3d 955, 961 (6th Cir. 2004). The Sixth Circuit does not necessarily require an extensive market analysis, but it does require at least a showing of the contours of an obvious relevant product and geographic market. *Id.* at 961 (precise product market was "neither obvious nor undisputed" and "simply will not suffice") and 962 (failure of plaintiff to "identify a relevant market" is grounds for dismissing Sherman Act claim).

The court of appeals decision in this case cannot be made to conform with the decision in *Worldwide Basketball*—the decision in this case allowed a quick-look analysis to occur, and a Section 1 violation to be found, without even a statement of a proposed relevant geographic or product market, let alone a showing that such markets were "obvious," "well-known," or "defined." The Commission makes no attempt even now to describe the relevant geographic or product market, and certainly does not demonstrate that these types of health care markets

are "obvious" or "well-known." Therefore, a conflict exists between the circuit courts regarding the necessity of *at least finding the contours of an obvious relevant market* before applying a quick-look analysis under *California Dental*.

CONCLUSION

For these reasons and those stated in its Petition, the petition for writ of certiorari should be granted.

Respectfully submitted,

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